S. HRG. 101-876

FREEDOM OF CHOICE ACT OF 1989

HEARINGS

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

S. 1912

TO PROTECT THE REPRODUCTIVE RIGHTS OF WOMEN, AND FOR OTHER PURPOSES

MARCH 27 AND MAY 23, 1990

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

28-873 -. WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S541-54

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THE FREEDOM OF CHOICE ACT OF 1989

TUESDAY, MARCH 27, 1990

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:45 a.m., in room SD-430, Dirksen Senate Office Building, Senator Howard M. Metzenbaum, presiding.

Present: Senators Metzenbaum, Adams, Hatch, and Coats.

Senator METZENBAUM. Good morning. This hearing will come to order.

We have a number of witnesses today and a number of distinguished members of Congress appearing. By reason of the large number of witnesses and the anticipated reality that there probably will be some need to go to the Floor on several occasions for votes, the chair will establish a 5-minute rule, and we will even hold our members of Congress to 5 minutes just so that we will have enough time available to hear all of the witnesses today.

There has been some discussion about some video presentations that witnesses on both sides have wanted to present. We will make time available at the conclusion of the hearing. After the hearing those video presentations can be had. The real purpose of the hearing is to have statements made by witnesses who can present factual arguments and legal arguments to the committee.

Having said that, I will make a short opening statement myself.

We begin a series of hearings today on S. 1912, the Freedom of Choice Act. This legislation was designed and introduced with one important goal in mind—to protect the right of a women to choose to terminate a pregnancy. It accomplishes this objective by codifying the U.S. Supreme Court's 1973 decision in *Roe v. Wade*. With this bill and these hearings, I hope we will send an unmistakable message to the women of this country: We are prepared to defend your right to choose. We are prepared to establish your right to choose by Federal legislation, whether or not the court reverses itself and overturns *Roe v. Wade*.

Since the U.S. Supreme Court's decision last year in *Webster v. Reproductive Health Services*, many States have been locked in fierce battles over legislation that, if enacted, would seriously threaten the right of women in these States to have an abortion.

Two weeks ago the Territory of Guam enacted a law that would outlaw abortions in virtually all cases. Last week Idaho enacted a law that limits abortions to certain instances involving rape, incest or fetal deformity. These statutes directly challenge the U.S. Supreme Court ruling in *Roe v. Wade*.

In the case of the Idaho law, the proponents designed the law with the purpose of inviting the U.S. Supreme Court to overrule *Roe v. Wade*. The court encouraged this counter-attack on women's rights by suggesting in *Webster* that the right to privacy announced in *Roe v. Wade* and upheld in subsequent cases does not have the status of other fundamental rights protected by the Constitution. This bill will stop the erosion of the essential principle that the decision is the woman's to make; it is her right to choose whether or not to have an abortion.

This bill is addressed to those States that have already restricted access to abortions. It reaffirms that we as a country will not go back to a time when abortion was a crime, and women died at the hands of unqualified and back alley abortionists. Moreover, it confirms that access to an abortion should not vary from State to State during the early stages of pregnancy.

Until last July, women who came of age during the post *Roe* era believed that the issue of reproductive choice was settled by the court and that their rights were secured from further State intrusion. After *Webster*, women can no longer trust the court to hold firm against attempts by States to restrict access to abortion. As a result, the country has been polarized by the issue of reproductive rights.

So again we will take up the issue of reproductive rights, because we must ensure that this country not return to a time when women risked their lives and their health to have an abortion. We will hear from people who remember that time; people who have experienced great difficulties during that time.

I am particularly pleased that we have such a distinguished list of Congressional spokespersons, both pro and con, on this issue.

We will lead off with Senator Cranston.

STATEMENT OF HON. ALAN CRANSTON, A U.S. SENATOR FROM THE STATE OF CALIFORNIA

Senator Cranston. Thank you very much, Mr. Chairman.

I am pleased to be here today to testify in support of S. 1912, the proposed Freedom of Choice Act of 1989, which the three Senators who are present at this side of the room introduced together—the Senator from Ohio, Mr. Metzenbaum, the Senator from Oregon, Mr. Packwood, and I were the prime movers last November, along with 20 other Senators from both sides of the aisle.

I want to begin by paying a special tribute to you, Senator Metzenbaum, and to you, Senator Packwood, for your work on the development of this vital measure and for your commitment and courage over so many years in advancing and protecting the right of American women to exercise freedom of choice in matters relating to abortion.

This truly bipartisan legislation is very simple, and it is very straightforward. It is designed to codify the 1973 *Roe v. Wade* decision and protect the rights of individual women to make their own decisions regarding whether or not to carry a pregnancy to term.

The *Roe v. Wade* decision basically holds that during the early stages of a pregnancy, prior to fetal viability, the decision regarding abortion must be left solely to the woman and her physician.

After viability, a State may regulate and even proscribe abortions, except when necessary to protect the life or health of the woman.

For 16 years, the U.S. Supreme Court rigorously enforced this rule of law, striking down legislation which interfered with the rights of individual women to make these decisions for themselves.

Last July, however, the U.S. Supreme Court sent a shock wave through the country when it handed down its decision in *Webster v. Reproductive Health Services*. The *Webster* decision has been interpreted to give State legislatures an open invitation to begin meddling with the exercise of this Constitutional right. The *Webster* decision has left us with an untenable situation. The fundamental right recognized under *Roe v. Wade* remains, but the court has signalled a willingness to apply a less stringent standard of review of State restrictions on the exercise of this right.

Already we have seen the results of this decision in places like Guam and Idaho, where legislation prohibiting virtually all abortions has very recently been approved.

This legislation is intended to restore the status quo that existed before the *Webster* decision and to assure that access to safe, legal abortions remains a guaranteed right in this Nation for all women, regardless of the State in which they reside.

The first hearing on this measure is focused on precisely the right question: What will happen in this country if access to safe, legal abortion services is eliminated?

The witnesses will provide some very real and graphic testimony about what life was like before the *Roe v. Wade* decision, when desperate women were forced into the hands of back alley butchers and when hospital emergency wards were filled with the victims of these illegal abortions.

The committee will also hear testimony of a witness from Romania who will describe the horrors that took place when the dictators of that country outlawed abortion, and illegal or self-induced abortions caused hundreds of deaths and thousands of cases of permanent injuries each year.

It is reported that Romanian women were forced by their government to submit to monthly pregnancy tests, and many women suffering the complications of illegal abortions stayed away from hospitals for fear of being reported to the secret police.

Could this happen in the United States? I'd like to say never. But if we start down the path of taking away freedom of choice from individual women, who knows where this will eventually end?

For example, last week in Guam, an attorney was charged under the restrictive new law with giving a speech stating that women in Guam could travel to Hawaii to obtain a legal abortion. The *Washington Post* in an editorial last week noted that this is a good reminder of how bad things could get if *Roe* is overturned.

We cannot allow the clock to be turned back. The Freedom of Choice Act is needed now to guarantee that women in this country will continue to have the right to make the difficult decision about abortion free from government intervention and control.

Abortion is a very emotional and controversial issue. There are strong feelings on both sides, often based upon deeply felt convictions and beliefs. But the lesson to be learned from Romania and from testimony you will hear this morning about illegal abortions

performed in the United States before the *Roe v. Wade* decision is clear: Outlawing abortion will not mean an end to abortion. It will only result in elimination of safe and legal abortion.

Mr. Chairman, I know you have a number of witnesses scheduled to testify this morning, so I will conclude at this point, and I thank you for the opportunity.

Senator METZENBAUM. Thank you very much, Senator Cranston. You certainly have been a leader in this area over a period of many years, and it is a privilege and a pleasure for me to have the opportunity to work with you.

Senator CRANSTON. Thank you.

Senator METZENBAUM. Senator Packwood.

STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM THE STATE OF OREGON

Senator PACKWOOD. Thank you, Mr. Chairman.

I am pleased to appear before the committee as an original sponsor of S. 1912, the Freedom of Choice Act.

I would like to begin with a quote from a statement I made on the Floor of the U.S. Senate as follows: "I am submitting this national abortion law today because the present laws are such a hodge-podge that the current situation in this country is chaotic, inconsistent, discriminatory and full of injustice."

Mr. Chairman, I did not make that statement in 1989 when we introduced the Freedom of Choice Act. I made that statement on May 3rd, 1971, when I introduced the National Abortion Act, which would have legalized abortions nationally. In spite of the lapse of nearly 20 years, I would be hard-pressed to come up with a more appropriate description of the present situation, and I would ask unanimous consent that the statement I made on the Floor of the Senate that day may be made part of the record.

Senator METZENBAUM. Without objection, so ordered.

Senator PACKWOOD. I would also like to have made part of the record a statement I made a year earlier, in 1970, when I introduced a legalized abortion bill in that Congress. I subsequently changed it slightly in 1971, but the tenor of both of them was the same; we were trying to protect a right for a women to make a choice without interference by the States.

Senator METZENBAUM. Without objection, that will be included in the record.

[The statements from the Congressional Record of Senator Packwood follow:]

Congressional Record

April 23, 1970

Pages 12672-12673

S. 3746—INTRODUCTION OF NATIONAL ABORTION ACT

Mr. PACKWOOD. Mr. President, back in February I introduced S. 3501, to legalize abortion in the District of Columbia. This bill was designed to take government out of the business of enforcing compulsory pregnancy and place the decision as to termination of an unwanted pregnancy where it rightfully belongs—with the pregnant woman.

When this bill went in, I indicated my hope that legal restrictions of the termination of an unwanted pregnancy would be removed in all the 50 States. At that time, I limited my bill to the District because I had some questions as to the legality of Federal jurisdiction over abortion, an area which has generally been left to the States. Having continued my research on this point, I am now convinced that a sound constitutional basis does exist for the enactment of a Federal statute legalizing abortion.

I am sure you will agree, Mr. President, that one of our most precious and basic constitutional guarantees is the right to privacy. Restrictive abortion laws—because they amount to compulsory pregnancy—blatantly deny a woman's most intimate right, the right to control her own fertility. The bill I introduce today, the National Abortion Act, is designed to guarantee and protect this fundamental constitutional right.

This National Abortion Act would legalize abortion and end compulsory pregnancy nationwide. It is an attempt to bring some order and logic into an area of law which in its confusion, vagueness, and unequal enforcement has, I believe, been cruel and discriminatory in its effects and therefore a serious burden to society.

It seems highly illogical, at this point in time, when there is so much concern over population growth, that the state should still be in the business of enforcing what biologist Garrett Hardin has called compulsory pregnancy. In this session of Congress alone, we have seen the introduction of a sizable number of bills aimed at studying the problems of population growth and at finding solutions to them.

Yet at the same time that we are discussing ways of preventing too many births, we are saying to desperate women who do not want to bear a child, "We shall punish you for your mistake by making you carry that child to term, no matter how careful you were in your efforts to avoid pregnancy, no matter how it will undermine your present family situation, no matter what happens to the unwanted child." I submit there is simply no sense to such a contradictory attitude.

There are those who oppose making it easier to obtain an abortion because they see it as a license to promiscuity. But surveys have shown that the majority of those who seek or have abortions are married women, often pregnant because of the failure of a contraceptive. A survey by Dr. Charles Westoff and Dr. Larry Bumpass revealed that among married women who do not intend to have any more children, one-third admit they have already had one unwanted child and 60 percent have had a failure in timing a pregnancy, less than one-quarter of all U.S. couples who have reached what they consider to be the end of their childbearing can be considered as completely successful so far in planning their fertility. With the failure rate of current contraceptive technology, there would still be several hundred thousand unwanted pregnancies each year among married women using contraceptives.

Furthermore, there are still several million American women who do not have access to family-planning services. We have been guilty in the past of failing to provide adequate medical services to these poor in our midst. Yet if through ignorance or lack of availability of services they become pregnant, we then insist they must become even more deeply mired in poverty by the addition of an unwanted birth.

There is no question but that in our hypocrisy or indifference we have made abortion much more available to the middle class than to the poor. Statistics available from New York City show that in the early sixties, 93 percent of therapeutic abortions—that is, those done in hospitals—were performed on white patients, 91 percent in private rooms. The ratio of in-hospital abortions to live births in New York City was approximately 1 to 360 for private patients and something like 1 to 10,000 in municipal hospitals. At the same time, the women whose deaths were associated with abortion in New York City in a typical year were 56 percent black, 23 percent Puerto Rican, and 21 percent white.

Congresswoman SHIRLEY CHISHOLM has found the same antiblack, antipoor policies existing in the District. While private hospitals were performing about 360 abortions monthly, D.C. General, the city's only public hospital, permitted only 27 abortions during the entire fiscal year 1969.

The poor, then, to escape compulsory pregnancy are largely forced to seek relief through illegal abortion. It is estimated that there are as many as 1 million illegal abortions a year in this country. Perhaps one-half are done by doctors, the others by those unscrupulous enough to make a profit out of such human misery, or by the woman herself. Deaths from botched procedures have been cut to perhaps 500 to 1,000 a year because of antibiotics, but the consequences of illegal abortion are still the leading cause of pregnancy-related deaths in this country. And there is still a widespread incidence of infection and permanent sterility from such bungling. Furthermore, the statistics do not cover the maiming of the spirit because of the humiliation and terror experienced by those seeking to terminate an unwanted pregnancy.

Our present system has also placed an unfair burden on doctors as they seek to apply their medical skill. Federal District Judge Gerhard Gesell has ruled recently that the provision in the District of Columbia statute which says that abortion may be done for "preservation of the mother's life or health" is unconstitutionally vague. This is typical of the provisions faced by doctors as they seek to abide by their States' legal codes. What is preservation of life—is it a mere matter of breath or is it something broader? Is preservation the same as saving life? Does the threat to life have to be imminent—and how imminent?

As a result of such criteria, vague yet carrying criminal sanctions, most doctors have naturally tended to be highly conservative in their interpretations, and most often the response has been a refusal. It has also been found that abortion policies vary not only from hospital to hospital but also from service to service within the same hospital, and even from doctor to doctor on the same service of the same hospital. How is the patient, particularly the poor patient, to find her path through such intricacies? And why should the doctor be expected to resolve such semantic and legal difficulties?

A doctor should be free, as in other matters involving his professional skill, to treat his patient in the light of his training, his judgment, and his assessment of the needs and total welfare of his patient, without having to arbitrarily refuse the requested treatment or to resort to subterfuges if he feels an abortion would be in her best interests.

There is an accelerating trend in this country toward reform or repeal of the abortion laws on the books, either through challenge in the courts or through the legislative process. California's supreme court last year threw out the State abortion statute and the U.S. Supreme Court refused to hear the appeal; a three-judge Federal panel in Milwaukee has declared Wisconsin's abortion law an "unconstitutional" violation of the right to privacy as guaranteed by the ninth amendment; and a Michigan district court has struck down that State's abortion law as unconstitutionally vague. Suits challenging the constitutionality of abortion restrictions are pending in several other States. In the legislative arena, Hawaii and New York have made abortion a medical matter between the doctor and his patient; Maryland is presently considering such a standard, and other States are moving toward action. For that reason, some may even question the need for a national policy on this matter, such as I am proposing today.

Experience seems to be demonstrating, however, that mere reform or liberalization does not solve the basic problem. Difficult criteria must still be weighed by doctors and hospitals. And in practice, reform has meant by and large that the poor and minority still have little access to abortion.

Furthermore, when some States act and others do not, when there are varying degrees of liberalization, there is a fear that the States with the most open policy will be beseiged by women from other States seeking abortions. Opponents of a loosening of restrictions hold up the specter of hospitals inundated with such women, literally preventing the hospitals from carrying on its other functions. This National Abortion Act would free States from the fear of this eventuality.

In any discussion on abortion—on the right of a woman to control her own fertility—the most fervent opposition comes in regard to the rights of the fetus. I do not dismiss this question lightly. But in discussions on the rights of the fetus, there is a conspicuous lack of consensus. Some religions oppose any relaxation of restrictions on abortion while a number of others have endorsed the principle of reform. The American Baptist Convention and the Universalist/Unitarian Church have come out for total repeal. Public opinion polls demonstrate that a majority of people, including a majority of Catholics, feel abortion should not be a matter of law.

Under this national act, no woman would be forced or even encouraged to have an abortion against her beliefs. No doctor would have to perform an abortion against his personal moral principles. But those with different religious or moral convictions would no longer be forced into compulsory pregnancies.

Let me bring up another point here—the origin of abortion laws. Contrary to popular belief, the legal structures against abortion are of comparatively recent origin. Until the early 19th century—at common law both in England and the United States—abortion before quickening was not illegal at all. Restrictions against abortion were not imposed until the early 1800's—but not to protect morals or the "soul" of the fetus, but rather because of the great danger of infection in any surgical procedure at the time. Abortions were allowed only where necessary to save the life of the mother—that is, where the risk of infection was outweighed by the risk of carrying that particular pregnancy to term. Today deaths from hospital abortions are virtually nonexistent, but meantime the statutes written to meet the needs of a bygone era have become frozen into our system of law. Mr. President, just look at the irony of this situation. The laws on our books were originally devised to protect women from a serious health hazard. They have now come full circle—under proper conditions, the health hazard is gone. But the laws remain on the books, infringing on millions of women's right to privacy, right to follow their own ethical convictions, right to control their own fertility. The injustice of this situation can no longer be ignored or tolerated.

I submit, Mr. President, that it is timely and right to change these laws. The right to privacy demands no less of us.

So I am introducing this National Abortion Act for your consideration. By it, burdens of guilt and suffering would be lifted from countless women; doctors would be freed to practice their profession in this area according to their best knowledge and skill; the problem of unwanted and unloved children would be eased; a discriminatory practice afflicting the poor could be abolished; the state would be taken out of the business of enforcing compulsory pregnancy and—most importantly—each woman would regain her right to control her own fertility.

The National Abortion Act will, I fervently hope, take abortion out of the realm of inconsistency and emotionalism and into the form of a rational and humane national policy.

The ACTING PRESIDENT pro tempore (Mr. EGGLAND). The bill will be received and appropriately referred.

The bill (S. 3746) to authorize abortions in the United States, introduced by Mr. PACKWOOD, was received, read twice by its title, and referred to the Committee on Labor and Public Welfare.

Congressional Record

May 3, 1971

Page 13137

By Mr. PACKWOOD:

S. 1750. A bill to authorize abortions in the United States. Referred to the Committee on Labor and Public Welfare; and

S. 1751. A bill to authorize abortions in the District of Columbia. Referred to the Committee on the District of Columbia.

Congressional Record

May 3, 1971

Pages 13155-13161

By Mr. PACKWOOD:

S. 1750. A bill to authorize abortions in the United States. Referred to the Committee on Labor and Public Welfare; and

S. 1751. A bill to authorize abortions in the District of Columbia. Referred to the Committee on the District of Columbia.

Mr. PACKWOOD. Mr. President, I rise today to introduce two bills designed to take government out of the business of enforcing compulsory pregnancy. The National Abortion Act would permit women nationwide to control their own fertility, by early termination of pregnancy if necessary, and the District of Columbia Abortion Act would do the same here in the District of Columbia. May I take a few minutes to explain why I believe Congress should deal with this controversial subject and why I think such legislation is both necessary and timely.

Certainly abortion is a controversial issue—and has been so for thousands of years. Through the centuries, the debate has been almost exclusively conducted by men. Claire Booth Luce, reviewing two recent books on abortion, points out that—

> Like so many of the books which learned men have written about "women's problems," this is really a book about the problem men are having with other men who refuse to see the "women's problem" as they do. The problem of the seven authors reviewed here is how to convince other moralists, lawyers and "separated brethren" that they should unite to prevent women (who else?) from getting abortions—legal or illegal.

The debate on abortion has also been centered almost entirely on theological discussions of when individual life—or personhood—begins. Churches and theologians have disagreed; most have changed their positions at some time; perhaps they will again. The question becomes even more complex as science moves into new areas of genetic engineering and cell reproduction. There seems no likelihood that moral aspects of the abortion question can ever be settled so as to be accorded unreserved acceptance by all.

Meanwhile, as the debate rages on, often obstruse, frequently shrill, the reality of what is happening in the world is almost lost sight of. Real women suffering. Real women are caught in tragic dilemmas—and the state has usually been in the position of trying to compel them to bear unwanted children.

The reality is that abortion takes place on a massive scale almost everywhere. It is estimated that some 30 to 35 million abortions take place each year around the world, millions of them in countries where the practice is absolutely forbidden. In the United States, estimates of induced abortions range from 200,000 to over 1 million a year. Mrs. Luce in the review cited above says that 800,000 to 600,000 may be a reasonable figure. But even if the low estimate were correct, it is sadly clear that the problem is enormous.

In the first 8 months of the repeal of the strict law against abortion in New York State, some 98,000 legal abortions were performed in New York City, a fact which horrified those opposed. But we must recognize that the law did not create a demand for abortion. The Reverend Howard Moody, one of the founders of the Clergy Consultation Service on Abortion, which counseled women with unwanted pregnancies, says that, at the time the new law went into effect, that organization alone was getting 100 calls a day asking for help. So the desire for abortion exists, regardless of what the law says. The question is not whether, but how society should best deal with it.

There are those who think we should step aside and hope the courts will decide the matter for us. On April 21, the Court issued a ruling on the District of Columbia's abortion statute, but the decision spoke only to the question of unconstitutional vagueness, and did not deal with the substantive issue involved, the right of a woman to control her own body and her own fertility, in accordance with her own ethical and religious convictions.

There are several cases coming before the Court which do deal with the substantive rights involved in abortion, but we cannot foresee whether the decisions rendered will be narrow or broad in scope, or in what direction they will move. It is an evasion of our responsibility as legislators to fail to act in the hope that someone else will.

I am submitting this national abortion law today because the present laws are such a hodgepodge that the current situation in this country is chaotic, inconsistent, discriminatory and full of injustice.

In a majority of States, abortion is permissible only when it is necessary to preserve the life of the mother, thus leaving doctors, hospitals or courts with the job of wrestling with just what that phrase means and when that condition prevails. At the opposite end of the spectrum are the laws of Alaska, Hawaii, Washington State, and New York which make the decision a matter between physician and patient. The other States have varying definitions of when abortion is permissible.

Furthermore, the situation is in a state of flux, with State legislatures moving in different directions—and strong countermovements underway to move them in the opposite direction. What is permissible this year may not be permissible next year; what is criminal today may be sanctioned tomorrow. How does this bring respect for law? What is a confused woman—or her husband—or her doctor to make of all of this?

What the present system means in practice is that a middle- or upper-class woman can usually get an abortion performed by a physician, no matter what the law says. She may have it in her own hospital with the procedure disguised under some other medical term or she can go to another State or another country where practice is more liberal. A national survey by Dr. Robert E. Hall* found that hospital abortions are performed four times as often in the private services as in the ward services.

Is a woman, deeply mired in poverty, frantic with concern over what another baby will mean in an already overburdened household, given no family planning assistance—is this woman less entitled to access to abortion than the equally frantic middle-aged woman of means who finds herself unexpectedly pregnant because of contraceptive failure at an age when she cannot think of coping with a baby?

A recent issue of a national news magazine carried a story about a new national computerized referral service, which will refer any woman applying for guidance to the nearest place she can go to have an abortion. With the confused legal situation, this is a logical development. But what of the woman who does not read national news magazines—and who would not have the money anyway to go where the service might refer her?

In States with supposedly liberalized laws, as well as in States with rigid ones, we require doctors' and hospitals' boards

*Robert E. Hall, "Abortion in American Hospital," *American Journal of Public Health*, November 1967, in Callahan, p. 137.

to do a Solomon-like weighing of intangibles. Dr. Hall quoted earlier has written:

> Abortion practices vary not only from hospital to hospital but also from service to service within the same hospital. They also vary widely from doctor to doctor on the same service of the same hospital. . . . The victim of all this confusion is, of course, the American female. Even if she has a legitimate reason for therapeutic abortion she must find Doctor X in hospital Y with policy Z in order to have it done.

One of the arguments used most often by those who oppose liberalizing their States abortion laws is the threat that such States will become "abortion mills." And of course as long as there is a wide variation in types of law, women will seek help in the more permissive States. Let me say again: The States with strict laws are not ending the practice of abortion; they are just forbidding legal abortions—at least for poor women. And they are forcing a few States to bear the responsibility of coping with the problem for all States. A national law would prevent this playing of one State against another.

In closing, may I list some of the benefits which I foresee from passage of these abortion bills.

First. It would clear the air by admitting that the practice of abortion exists and should be brought into the open where it can be dealt with according to safe medical procedures. Deaths and maiming from abortion could be virtually eliminated.

Second. It would command respect as an evenhanded law, enforceable, fair, nondiscriminatory, protecting and giving the same right to every woman, whatever her race or social class, wherever she may live. It would take the State out of the business of enforcing compulsory pregnancy on unwilling women.

Third. It would leave the moral, ethical, and religious issues to the individual conscience, guided by whatever counselor is trusted, leaving the legislature to protect the civil rights of the individual. Churches and other organizations would be free to advocate their positions as fervently as they wish. While the numbers of abortions might rise with such a law, at least first, there is also the possibility that when women could seek assistance and counseling more openly, without fear, some abortions would be averted as other support and alternatives were offered. We might hope that the decision to deal with this problem on a national scale, thereby for the first time really revealing the scope of the problem would serve as a challenge to greater effort for those who say better social conditions are the solution to the problem of abortion.

Fourth. It would leave doctors free to practice medicine, and hospitals to furnish facilities for such medical practice without foisting on them the burden of trying to interpret the will of society and of making decisions the rest of us do not want to face up to.

Fifth. It would insure that virtually all abortions would be done at an early stage of pregnancy. One of the emotional issues raised whenever changing abortion laws is discussed, is the specter of viable fetuses being delivered and allowed to die. Because of the genuine concern of many, I have incorporated in this bill a very conservative time limit—20 weeks—within which an abortion would be allowed. This would make absolutely certain that there would be no abortion of a viable fetus.

In the past, one basic reason for late induced abortions has been the difficulty in obtaining an abortion. A woman may spend precious time seeking out psychiatrists as required by law, appearing before a hospital board, awaiting the decision of the board—and then perhaps being rejected. More time then is consumed in seeking approval at another hospital or finding a more compassionate doctor or locating an out-of-State clinic.

A national policy assures each woman the right to make a decision together with her doctor, based on her own beliefs and her own circumstances. If the decision is affirmative, the abortion can be done very soon thereafter. The only indication for a late abortion then would be a condition which endangered the mother's life or health and which did not develop or was not recognized until after 20-week limit, and that would be a decision made on strictly medical grounds.

Daniel Callahan, former editor of Common Weal and a Catholic generally opposed to abortion on moral grounds, made an exhaustive study of the subject last year and published the results in his book, "Abortion: Law Choice and Morality." He concluded that, in our pluralistic society, a permissive abortion law is the best solution to a problem that has no perfect answer.

He says:

> I do not believe that any solution to the legal problem but that of abortion on request is either possible or desirable in our society. It is not possible because thousands of women believe they have a right to abortion, and they are supported by important professional, legal and medical groups. Restrictive laws cannot and will not be enforced. Many will believe themselves grave injured by such laws—and in terms of their moral convictions they will be. Moderate laws offer few if any advantages over restrictive laws; they simply do not work, offering neither any greater expansion of individual choice nor any more just a resolution of conflicts. (The Ecumenist, May-June 1970.)

When there is a perfect contraceptive; when there is universal availability of counseling, sex education programs and family planning services; when there is no more poverty or crime; when there are no more diseases or drugs to deform the growing embryo—when that day comes, there may indeed be an end to abortion. The end will not come because of strict laws against it, nor by threatening nor damning suffering women. For this imperfect world in which we must live and make decisions, I submit these National and District of Columbia Abortion Acts, which I firmly believe will save lives and families, and strengthen society and its precious fabric of law.

I ask unanimous consent to have the bills printed at this point in the RECORD, along with a partial listing of religious, medical, and other organizations which have endorsed by resolution the concept of legalized abortion. I also ask unanimous consent to have printed in the RECORD three very thoughtful articles on abortion, one by former Supreme Court Justice Tom Clark, another by Rabbi Israel R. Margolies, and a third by former Boston College of Law Dean, and now Congressman ROBERT F. DRINAN.

There being no objection, the bills and material were ordered to be printed in the RECORD, as follows:

S. 1750

A bill to authorize abortions in the United States

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "National Abortion Act".

SEC. 2. As used in this Act, the term—

(1) "physician" means any person licensed under the laws of any State to practice medicine, or any person who practices medicine in the employment of the Government of the United States or of any State; and

(2) "State" means any of the several States of the United States, the District of Columbia, any area within any of the several States over which the United States has exclusive or concurrent jurisdiction, the Commonwealth of Puerto Rico, and the territories and possessions of the United States.

SEC. 3. (a) Subject to the provisions of subsection (b), any physician is authorized to perform, by such means as he deems appropriate, an abortion on any female person who requests that action. No abortion shall be performed by any physician on any female person under the authority of this Act unless performed within the first one hundred and forty days of such person's pregnancy, except in any case where, in the judgement of the physician performing such abortion, a failure to perform such abortion is likely to endanger the life or health of such female person.

(b) A physician other than a physician who practices medicine in the employment of the Government of the United States or any State, is authorized to perform an abortion in accordance with this Act only in a State in which he is licensed under the laws thereof to practice medicine.

SEC. 4. The laws of any State or political subdivision thereof inconsistent with any provision of this Act are, to the extent of that inconsistency, hereby superseded.

S. 1751

A bill to authorize abortions in the District of Columbia

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That any physician is authorized to perform, in the District of Columbia, by such means as he deems appropriate, an abortion on any female person who requests that action. No abortion shall be performed by any physician on any female person under the authority of this Act unless performed within the first one hundred and forty days of such person's pregnancy, except in any case where, in the judgement of the physician performing such abortion, a failure to perform such abortion is likely to endanger the life or health of such female person.

SEC. 2. As used in this Act, the term "physician" means any person licensed under the laws of the District of Columbia to practice medicine, or a person who practices medicine in the employment of the Government of the United States or of the District of Columbia.

RELIGION, MORALITY, AND ABORTION: A CONSTITUTIONAL APPRAISAL

(By Mr. Justice Tom C. Clark)

Thought without action is an abortion; action without thought is folly.

Our society is currently in the midst of a

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sexual revolution which has cast the problem of abortion into the forefront of religious, medical, and legal thought. In my day at the bar all discussion of abortion was taboo. For more than sixty years the American Medical Association had a negative policy respecting abortion. The A.M.A. often sought the prosecution of any doctor who engaged in the practice of abortion, regardless of the merits of the individual situation. Society's general attitude toward abortion was such that the patient was ostracized and the doctor was disgraced. As in so many other facets of its moral code, however, society was hypocritical in its behavior. Despite the public pronouncements against its practice, abortions increased, especially among married women, and judicial action against the participants decreased in proportion.[7]

Some social commentators argue that Freud prepared the way for the Kinsey Report, which in turn set the stage for the sexual permissiveness that Reinhold Niebuhr called "moral anarchism."[8] This permeating permissiveness engendered a need for more efficient birth control methods, such as "the pill," and precipitated the doom of the old hypocrisy.

The law, lagging behind as usual, began to emerge from its quagmire and rid itself of the archaic restraints on abortion. In 1962 the American Law Institute proposed an affirmative policy declaring that the termination of pregnancy is justified whenever (1) its continuance would gravely impair the physical or mental health of the mother, (2) the child would be born with grave physical or mental defects, or (3) the pregnancy was the result of rape, incest, or other felonious intercourse.[9]

Within five years of this proposal, the A.M.A. reversed its negative policy and adopted the A.L.I. proposal with only a few nuances.[10] During the next two years, five states liberalized their abortion laws and adopted the A.L.I. proposal.[11]

A further liberalization occurred in Great Britain with the adoption of the 1967 Abortion Act, which permits doctors to consider the mother's "actual or foreseeable environment" in deciding whether an abortion is necessary.[12] The American College of Obstetricians and Gynecologists (A.C.O.G.) recently advocated enactment of similar legislation in this country.[13] While the permissiveness of the legislation would contradict existing laws in all states, the A.C.O.G. made it clear that it does not counsel disobedience to the law. It merely recommended liberalization and repeal of inconsistent laws. It did not, however, advocate the legalization of abortion for any unwanted pregnancy or as a population control device.

Various religious, medical, psychological, and legal organizations have been striving to reach some level of accord on the issues involved in promulgating a realistic and acceptable policy toward abortion. Emphasis on this topic is the result of many factors, including the chaotic state of thinking that prevails among the professions and the public, and the medical, emotional, and legal consequences which abortocide has on today's society.

The Christian Medical Society's symposium on controlling human reproduction provides a recent illustration of the disagreement that exists among professionals concerning abortion. Distinguished clerics, psychologists, doctors, and lawyers sought to determine what course of action should be followed. They were unable to answer many important questions, such as: Is the control of human reproduction against the will and spirit of God? At what stage of the gestation period does the fetus acquire human status? What are the constitutional limitations upon the State in prohibiting or limiting the control of reproduction? I ask myself "Heaven knows: who can tell? Who shall decide when experts disagree?" These and many other questions must be answered if we are to attain our goal of an abortocide policy that is responsive to modern society's needs and desires.[9]

In a recent conference the Association for the Study of Abortion experienced far greater success in agreeing on an abortocide policy. Dr. Robert Hall, president of the Association, said that the conference was designed to "relate what we know about abortion, and to determine what, if any, extent our attitude toward abortion should change with changing times. . . ."[9] The Conference reviewed numerous reports dealing with present abortion laws. One of these reports concerned the effect of California's recently liberalized abortion law. It was noted that while the number of therapeutic abortions performed in California hospitals this year will rise from six hundred to about four thousand, there will continue to be some one hundred thousand illegal abortions performed in that state, because doctors are concerned about risking a prison sentence for an incorrect interpretation of ambiguous provisions of the liberalized law.[14] The conference was also informed that psychiatrists and physicians in various states were referring patients to doctors in states which have more liberal abortion laws. This practice renders the availability of legal abortion dependent upon the woman's ability to reach such states.[15] Many doctors admitted privately that they and most of their non-Catholic colleagues perform several illegal abortions each month. Kenneth R. Whittemore reported that his recent interviews revealed that in one small Southern city, women had a choice between "a chiropractor, an antique dealer, a midwife, a mechanic and a doctor dissatisfied with his profession to perform the operation."[16]

The Association reached an almost unanimous conclusion that all abortion laws should be abolished and that the right of childbirth should be left to each woman acting on the advice of her doctor. This would have the effect of removing the issue from the hands of the legislatures and the courts, which are virtually helpless to decide an ethical question as controversial and far-reaching as abortion.[9] Whether or not we agree with the Association's recommendations, it is readily apparent at this point that a uniform scheme concerning abortion is highly desirous.

Throughout history religious belief has wielded a vital influence on society's attitude regarding abortion. The religious issues involved are perhaps the most frequently debated aspects of abortion. At the center of the ecclesiastical debate is the concept of "ensoulment" or "personhood," *i.e.*, the time at which the fetus becomes a human organism. The Reverend Joseph F. Donceel of Fordham University admitted that no one can determine with certainty the exact moment at which "ensoulment" occurs, but we must deal with the moral problems of aborting a fetus even if it has not taken place.[9] Many Roman Catholics believe that the soul is a gift of God given at conception. This leads to the conclusion that aborting a pregnancy at any time amounts to the taking of a human life and is therefore against the will of God. Others, including some Catholics, believe that abortion should be legal until the baby is viable, *i.e.*, able to support itself outside the womb. In balancing the evils, the latter conclude that the evil of destroying the fetus is outweighed by the social evils accompanying forced pregnancy and childbirth.[9]

Many civilizations of antiquity prohibited the practice of abortion. Ancient Judaism prohibited birth control except in times of famine.[17] Assyrian law imposed the death penalty upon any person participating in an abortion, including the procurer.[18] Even pagan writers described abortion as an evil act prohibited by law.[19]

The New Testament is devoid of pronouncements bearing directly on the issue of birth control or abortion. The Old Testament, however, does not condemn abortion as a capital offense since the fetus was not regarded as possessing a soul within the Sixth Commandment proscription.[20] It does declare, however, that conception is a gift of God which can be withdrawn at His will.[21] Many theologians today argue that man must not destroy what God has created and that aborting a pregnancy destroys the gift of human life.[22]

The medical profession is far from agreeing on the time at which the fetus becomes a human life. Some physicians argue that abortion should be permitted with impunity at any time up to the sixth months of pregnancy since prior to that time the fetus is no more than a growing plant.[23] On the other hand, many eminent physicians believe that the fertilized ovum has human life from the time of conception.[24] In support of this argument they refer to the International Code of Medical Ethics, which states that a physician will maintain the utmost respect for human life, from the time of its conception. A third view is that the decision to terminate a pregnancy must be made according to the circumstances of the particular case. Among the factors to be considered are the duration of the pregnancy, the physical and mental health of the mother, and the risk of serious fetal abnormality. This places the burden of decision upon the doctor and renders the selection of the physician a governing factor in securing permission to perform a therapeutic abortion.[9]

Sociologists have found themselves in a similar quandry over the issue. Some of these social philosophers argue that man is not merely a chemical machine and that he possesses a soul from the earliest stages of fetal development. Therefore the fetus cannot be destroyed with impunity. The control of human reproduction, according to this view, should concentrate on the prevention of conception rather than on abortion.[9] Other sociologists believe that there is no conclusive evidence or persuasive argument that the fetus is human.[9] Indeed, it cannot interact with other human beings. Therefore, there is no proof of life in the sense that the law contemplates proof of fact.

The moving spirit of the times also raises moral issues that divide the disciplines within themselves. A group of one hundred psychiatrists were questioned on the morality of abortion.[9] Twenty-four agreed that abortion should be available upon demand at an appropriate stage of pregnancy. Fifty-six, however, would require consideration of all of the medical and social factors involved in each case before deciding whether to terminate the pregnancy. Sixteen of those questioned would abort only when actual or threatened maternal disaster was present. Only four expressed other views. While this indicates a vast departure from the Christian concept, it does reveal residuals of morality affecting the opinions of over two-thirds of the group. In other words, over two-thirds of the group would not abort a pregnancy solely on demand.

Despite the fact that religious belief continues to permeate our attitude toward abortion, most people today agree with Justice Holmes that "moral predilections must not be allowed to influence our minds in setting legal distinctions."[25] This is illustrated by the fact that the present change in attitude toward abortion has developed while the need for abortion has diminished as a technique to save the life or health of the mother or to prevent fetal deformities. Despite the medical developments, the demand for abortions has increased astronomically.[26] This indicates a definite change in social mores, which is undoubtedly the result of increased knowl-

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edge and use of abortion. This attitude of permissiveness is replacing the hypocrisy that prevailed in the last generation.

A major contributing factor to this change in attitude has been the growing antagonism toward the double standard which permits those with social status and financial ability to obtain abortions, while those in the lower social and economic classes are denied this opportunity. We are in the midst of a world-wide movement to make "the pill" and abortion available in the slums as well as on Fifth Avenue. The statistics illustrate the disparity between the affluent and the nonaffluent. Three counties surrounding San Francisco are relatively affluent. These counties account for sixteen per cent of the live births and fifty per cent of the abortions in California. The less affluent Los Angeles County with its widespread slum areas accounts for sixty per cent of the live births and twenty-three per cent of the abortions in California." These facts demonstrate quite clearly that the affluent areas account for a number of abortions disproportionate to their population density.

The increasing number of abortions subjects physicians to increased dangers of liability for incorrectly interpreting a statute. It appears that doctors face an uncertain fate when performing an abortion. This uncertainty will continue unless the legislatures or courts provide relief from liability. Very few states, if any, will repeal all abortion laws as the Association for the Study of Abortion has recommended. Some states, however, may liberalize their laws in accordance with the A.L.I. suggestion, but we have already seen that in states such as California this is an inadequate remedy in many respects. If the medical profession is to be accorded complete protection, it will have to come through the judicial system.

The Supreme Court of the United States has gone far—some critics contend too far—in permitting individual action in the areas of the Bill of Rights. It has not, however, dealt directly with the problem under discussion, nor do the decided cases cast much light on its solution. The best that we can do is examine related areas and draw some analogies.

In 1922 the Court held that the right "to marry, establish a home and bring up children" was an essential liberty within the guarantees of the Fourteenth Amendment.[1] In 1925 a public school statute requiring attendance exclusively at state schools was declared unconstitutional on the ground that it unreasonably interfered "with the liberty of parents and guardians to direct the upbringing and education of children under their control."[2] This concept was later extended to include "the private realm of family life which the state cannot enter."[3] And in 1960 the Court declared, in very broad language, that where State action significantly encroached upon personal liberty, its action would be invalid unless the State had a compelling subordinating interest in the particular activity.[4] Finally, in *Griswold v. Connecticut*[5] the Court struck down the state's statute prohibiting the use of contraceptives. The statute was found to operate upon "an intimate relation of husband and wife" which came within the zone of privacy created by several fundamental constitutional guarantees, the penumbras of which gave protection to the sanctity of a man's home and the privacies of his life. The Court determined that the statute was aimed at use rather than regulation and therefore violated the principle that legislation must not be unnecessarily broad. This does not mean that judges are given a free rein to strike down state regulatory statutes. They must look to the collective conscience of our society in determining which rights are fundamental and therefore protected by the Constitution.

The result of these decisions is the evolution of the concept that there is a certain zone of individual privacy which is protected by the Constitution. Unless the State has a compelling subordinating interest that outweighs the individual rights of human beings, it may not interfere with a person's marriage, home, children, and day-to-day living habits. This is one of the most fundamental concepts that the Founding Fathers had in mind when they drafted the Constitution. No one will deny that a State has a valid interest in regulating the well-being of its inhabitants, especially when it is dealing with children, who are more susceptible to undesirable influences. We have also seen that a State may not unreasonably interfere with the intimate relations of its inhabitants. When deciding on the constitutional restraints imposed on a State's interference with individual rights, the vital question becomes one of balancing. It must be determined at what point the State is interfering with individuals and at what point it is exercising valid authority by regulating the well-being of children.

In his concurrence in *Griswold*, my brother Goldberg asked whether a decree requiring all husbands and wives to be sterilized after the birth of ten children would be valid. He answered the question in the negative.[6] But suppose that the husband and wife voluntarily submitted to sterilization. Would it then violate the Constitution? I think no. Does it therefore know that voluntary destruction of the fetus is also protected from interference by the State? Perhaps—unless life is present so that the State's compelling subordinating interest in the life of one of its people predominates. However, I submit that until the time that life is present, the State could not interfere with the interruption of pregnancy through abortion performed in a hospital or under appropriate clinical conditions. I say this because State interference is permissible only if reasonably necessary to the effectuation of a legitimate and compelling State interest.[7] Prior to the time that life is present in the fetus, what interest does the State have? Procreation is certainly no longer a legitimate or compelling State interest in these days of burgeoning populations. Moreover, abortion falls within that sensitive area of privacy—the marital relation. One of the basic values of this privacy is birth control, as evidenced by the *Griswold* decision. Griswold's act was to prevent formation of the fetus. Thus, the Court found, was constitutionally protected. If an individual may prevent conception, why can he not nullify that conception when prevention has failed?

The common law courts uniformly held that an infant could not be the subject of a homicide until its complete expulsion from the body of the mother and the establishment of an independent existence.[8] The distinction between fetal life and independent life is that the latter has an independent circulatory system.[9] Hence, where the evidence showed that an infant was killed before its birth was complete or was killed by means used to assist in its delivery, it was not deemed a homicide.[10] Therefore, under the common law, abortion could not be murder. These concepts and distinctions have been somewhat eroded in recent years. At present the courts do not agree on the time when life begins. The courts, however, have held an *accoucheur* responsible for prenatal damage to an infant in a viable state.[11] In this line of cases, the courts have found that the unborn infant was a separate biological entity and hence a legal one in contemplation of law, indicating a departure from the requirement of an independent existence. From this reasoning the courts naturally take the unborn child into their protective custody. Indications of such a trend are illustrated by the abolition of the viability rule in some jurisdictions[12] and the repudiation of the "live birth" doctrine by fourteen states.[13]

To say that life is present at conception is to give recognition to the potential, rather than the actual. The unfertilized egg has life and if fertilized, it takes on human proportions. But the law deals in reality, not obscurity—the known rather than the unknown. When sperm meets egg life may eventually form, but quite often it does not. The law does not deal in speculation. The phenomenon of life takes time to develop, and until it is actually present, it cannot be destroyed. Its interruption prior to formation would hardly be homicide, and as we have seen, society does not regard it as such. The rites of Baptism are not performed and death certificates are not required when a miscarriage occurs.[14] No prosecutor has ever returned a murder indictment charging the taking of the life of a fetus. This would not be the case if the fetus constituted human life.

It has been urged that the courts are the proper forum to determine when life begins. I submit, however, that the professionals are better able to determine when life begins than are the courts. Tort cases might cast some light on the issue,[15] but I would prefer that the courts yield to the expert testimony of doctors. This testimony would vary greatly, but that is nothing new to our judicial system.

This is not a question that will be easily resolved. Few questions that reach the Supreme Court are. As was stated at the Christian Medical Society's Symposium, "professionals . . . do not wish to play God with human lives, whether in being or inchoate with life. But we can inform our judgment . . . by a widest interchange, airing and consensus. Humility is a large part of every professional's code."[16] It must be remembered that many imponderables are a part of Supreme Court adjudications.

Accommodation of conflicting doctrine is more difficult to achieve in the judicial than in the legislative process. Courts cannot reach out to reform our society. A problem comes to the Court in the form of a justiciable issue and is narrowly drawn, rendering the Court's ruling contracted and finespun. Legislatures, on the other hand, have such facilities for investigation as hearings and may address themselves to the necessities of broad social needs and the correction of evils, both probable and existing. As Mr. Justice Cardozo said, "Legislation can eradicate a cancer, right some hoary wrong, correct some definitely established evil, which defines the feebler remedies, the distinctions and the fictions familiar to the judicial process."[17]

The courts work on a case-by-case system which deals with the past rather than the future. Society would not have the benefit of the sweeping effect of a statute, nor would the doctor have the protection that he is entitled to receive. The case method would be slow, expensive, and possibly disastrous. It is for the legislature to determine the proper balance, *i.e.*, that point between prevention of conception and viability of the fetus which would give the State the compelling subordinating interest so that it may regulate or prohibit abortion without violating the individual's constitutionally protected rights.

The present climate seems favorable for immediate legislative action. Five States have already led the way.[18] With appropriate action, many more will follow suit in liberalizing their abortion laws. But this process will take less talk and more action. As Nehru once said:

> I am tired of people who merely talk about things. However wise you may be, you can never enter into the spirit of a thing if you only talk about it and do nothing. Even scientists have a tendency to let a wonderful

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experiment remain an experiment once it has been performed. The next stage somehow does not come. They may well say that the next stage is somebody else's job, but I think if the scientist had a sense of practical application, he would either try to do it himself, or get somebody else to do it. This association of thought with action is, I think, of utmost importance. Thought without action is an abortion; action without thought is folly.[98]

FOOTNOTES

[1] Associate Justice, Supreme Court of United States (Retired), 1949–67.

[2] *The Wisdom of Nehru*, 34 Wisdom 62 (The Wisdom of India ed. 1960).

[3] R. Thomlinson, Population Dynamics 198–99 (1965).

[4] Niebuhr, *Kinsey and the Moral Problem of Man's Sexual Life*, in An Analysis of the Kinsey Reports on Sexual Behavior in the Human Male and Female 62 (D. Geddes ed. 1954).

[5] Model Penal Code § 230.3(2) (Proposed Official Draft, 1962).

[6] Committee on Human Reproduction, *AMA Policy on Therapeutic Abortion*, 201 J.A.M.A. 544 (Aug., 1967).

[7] Cal. Health & Safety Code §§ 25950–54 (West Supp. 1967); Colo. Rev. Stats. 40–2–50 (Perm. Comm. Supp. 1966); Ga. Code Ann. § 26–1202 (effective July 1, 1969); Laws of Md. ch. 470 (Supp. 1968); N. C. Gen. Stat. § 14–45.1 (Supp. 1967).

[8] Abortion Act 1967, c. 87, at 2033.

[9] *Just How Great Are the Risks of The Pill?* Medical World News, May 24, 1968, at 23.

[10] The theological and medical scholars did agree on *A Protestant Affirmation*. It did not undertake to answer any of the questions posed in the text. In substance, the consensus concluded that as to abortion "each case should be considered individually, taking into account the various factors involved and using Christian principles of ethics." It suggested that suitable cases for abortion would fall within the scope of the A.C.O.G. statement, but not including abortion for convenience only or on demand. *See* Christian Med. Soc'y J. (Nov.-Dec. 1968).

[11] Meeting of the Ass'n for the Study of Abortion, Hot Springs, Va., Nov. 18, 1968, reported in N.Y. Times, Nov. 24, 1968, at 77, col. 1.

[12] *Id.*

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] For studies in this area see L. Epstein, Marriage Laws in the Bible and the Talmud (1942); L. Epstein, Sex Laws and Customs in Judaism (1948).

[19] H. Sagg's The Greatness That Was Babylon 218 (1962).

[20] Pauly's Real-Encyclopädie der Classischen Altertumswissenschaft (Wissowa ed. 1962).

[21] *Exodus* 3:21.

[22] *Genesis* 1:28, 4:1, 11:30; *Ruth* 4:13.

[23] Montgomery, *How to Decide the Birth Control Question*, Christianity Today, March 4, 1966, at 10.

[24] Stern, *The Issue of Legalized Abortion*, 96 Can. Med. Ass'n J. 808 (1963); J. Fletcher, Morals and Medicine 183 (1967); address by E. Eddinton, Symposium of Christian Medical Society, Aug., 1968.

[25] *See generally* Philosophy and Ethics in Medicine (M. Gelfand ed. 1964).

[26] *See Therapeutic Abortion*, 98 Can. Med. Ass'n J. 512 (1968).

[27] R. Ettinger, The Prospect of Immorality 132 (1962). *But see* Hudeczek *De Tempore Animationis Foetus Humanis Secundum Embryologiam Hodiernam*, in XXIX Angelicum 163–81 (1952). *See also Cyronics and Orthodoxy*, XII Christianity Today 816 (1968).

[28] Address by John Scanzoni, Ph. D., Assoc. Prof. of Sociology, Indiana Univ., Nat'l Convention of Christian Medical Society, Aug., 1968.

[29] Howells, *Legalizing Abortion*, 1 Lancet 726 (1967).

[30] O. W. Holmes, The Common Law (1881).

[31] *The Cost of Life*, 60 Proceedings of Royal Soc'y of Medicine 1235 (1962); Cogan, *A Medical Social Worker Looks at the New Abortion Law*, 2 British Med. J. 235 (1968).

[32] N.Y. Times, Nov. 24, 1968, at 7, col. 1.

[33] Meyer v. Nebraska, 262 U.S. 390 (1923).

[34] Pierce v. Society of Sisters, 268 U.S. 510, 534–35 (1925).

[35] Prince v. Massachusetts, 321 U.S. 158 (1944).

[36] Yates v. Little Rock, 361 U.S. 616, 524 (1960).

[37] 381 U.S. 479 (1965).

[38] Id. at 482.

[39] Id. at 503 (concurring opinion).

[40] Morgan v. State, 148 Tenn. 417, 256 S.W. 433 (1923).

[41] State v. Pruitt, 76 Miss. 543, 24 So. 871 (1886).

[42] Evans v. State, 48 Tex. Cr. App. 589, 89 S.W. 974 (1905).

[43] Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946).

[44] See Prosser on Torts (3d. ed. 1964).

[45] Del Tufo, Recovery for Prenatal Torts: Actions for Wrongful Death, 15 Rutgers L. Rev. 61 (1960).

[46] Schwartz, Abortion and 19th Century Laws, Trial June-July, 1967 at 41.

[47] Kwaterski v. State Farm Mut. Ins. Co., 34 Wis. 28, 14, 148 N.W. 3d 167 (1887); Halata v. Markiewicz, 26 Conn. Supp. 358, 224 A.2d 466 (1966). Contra, Norman v. Murphy, 124 Cal. App. 2d 95, 268 P.2d 178 (1964); Marko v. Philadelphia Transp. Co., 420 Pa. 124, 216 A. 2d 302 (1966).

[48] Prof. Thomas Lambert, Jr., Editor-in-Chief, American Trial Lawyers Ass'n, former Prof. of Law, Boston Univ.

[49] B. Cardozo, Growth of the Law 234 (1924).

[50] Georgia, Maryland, North Carolina, California, and Colorado.

[51] Wisdom, supra note 1.

Abortion and Religion

(By Rabbi Israel R. Margolies)

The moral implications and desperate need for legalizing abortion were dramatically demonstrated a little over three years ago in the Finkbine case in Arizona. We were confronted and shamed as a nation by the spectacle of a decent, intelligent American woman vainly seeking court sanction for an abortion, in order to prevent the birth of a child who probably would be, as events later proved, actually was, horribly deformed. The medieval and barbarous cruelty of the abortion laws in the U.S. was clearly exposed when Mrs. Finkbine was compelled to seek the compassion and help abroad that were denied in her own country. This was the only alternative to the very real threat of bringing into the world a pitiful creature whose life would be darkened with such pain, sorrow, and frustration as no one could possibly calculate, and whose very existence would be a curse upon its parents.

Judaism considers man the active, responsible partner of God in the task or establishing the Kingdom of God—not in some far-off celestial sphere, or in some distant apocalyptic age under the leadership of a Messianic miracle man—but right here on earth. Indeed, Judaism suggests that having created the universe, God, while vitally concerned about all that occurs on this planet, has deliberately left the work of human history and creativity to man. I believe that the ideal world that all of us yearn to see, the world of universal justice and lasting peace, will not be bestowed by God upon man, but rather must be created by man to the greater glory of God.

Surely man, who was endowed by God with the intelligence to master nature, and the spiritual strength to bend that intelligence to the fulfillment of the Divine plan, was also intended to exercise his own free will in determining whether or not to bring the fruit of his seed into the world. If the sexual function of man was meant to be directed strictly to the purpose of procreation, then, like other members of the animal kingdom, he would have experienced the sexual urge solely on regular, set occasions, devised by nature for the perpetuation of the species.

However, the fact is that man alone has been granted the boon of an unrestricted sexual appetite as an intimate expression of love that is unlimited by time or season. How he exercises this privilege is undeniably of some moral and legal concern to the community—but, as long as a man and woman find it appropriate to fulfill their love for and joy in each other through sexual intercourse, there is no law of nature or of God that requires that such love and joy must perforce lead to conception and birth. It is a man and a woman who must decide whether or not they wish their union to lead to the birth of a child, not the church or the synagogue, and certainly not the state.

Until a child is actually born into the world, it does not belong to society, nor has it been accepted into any faith. Its existence is purely and entirely the business and concern of its parents, whether they are married or not. They and they alone have the right to determine whether the unborn foetus shall live, or be abortioned in its pre-natal state. I have heard, as all of you have heard, ad infinitum and ad nauseum the backneyed argument that such abortions would serve to encourage immorality in pre- and extramarital adventures. To this time-worn contention I would say in the first place that those who choose to indulge in such casual relationships are usually sufficiently adept in the use of contraceptives that abortions are rarely sought. The ones who are most frequently caught, so to speak, are either the very young and inexperienced, or the very poor and ignorant, and it is precisely in these situations that reluctant and embittered parenthood should be avoided. In the second place, I would soberly and respectfully suggest that such excesses, even if they did indeed result in part from the legalizing of abortion, would be infinitely preferable to the endless, careless, and purposeless ushering of millions of unwanted and unloved children into an already teeming and highly competitive society. In the January 31st edition of the magazine section of the *New York Times*, Julius Horwitz, in an article entitled, "The Arithmetic of Delinquency," quotes women who want no more children, but who, on bringing a new baby home from the hospital, "hate him for being alive." These are the rejected and neglected children who make up the vast majority of our delinquents, and then proliferate and repeat the vicious cycle further.

According to traditional Jewish law, and I quote from the Talmudic tractate Oholos 7: 6: "If a woman has great difficulty in giving birth to her child, it is permitted to destroy the child to save her life." The law continues to say that if the child puts forth its head or most of its body, it may no longer be destroyed to save its mother, since as the Talmud puts it, "we do not push aside one life for another." From this statement, we may conclude that abortion during the foetal or pre-natal period is permissible even in cases where the mother's survival is not the prime purpose. Only when a child is about to be born, and has actually begun to emerge, is it termed "nefesh," a living soul; and only then may we not "push aside one life for another." Prior to actual birth the unborn infant is not deemed truly

to be a living soul, a human being. If it should die during birth, or even during the first 30 days of infancy, no funeral service is held, no Kaddish, or memorial prayer for the dead need be recited, because this tot is not considered to have lived at all.

Rabbi Jacob Emden, the most brilliant Talmudic scholar of the 18th century, was asked whether a pregnant adultress may have an abortion. This great authority, who revered Jewish tradition, answered boldly in the affirmative, and went on in his explanation to suggest that we may destroy the foetus, not only to save the mother's life, but even to save her excessive torture in childbirth. The most liberal statement on the general subject of abortion was given by the late Sephardic Chief Rabbi Ben Zion Uziel. He concluded, after a broad analysis of the subject, that an unborn foetus is not a "nefesh"—a soul—at all and has no independent life. It is part of its mother, and just as a person may choose to sacrifice a limb of his body in order to be cured of a worse malady, so may the foetus be destroyed for the sake of its mother.

While there are, to be sure, differences of opinion among some other Jewish scholars with regard to abortion, the position of the men whom I have cited is, in my carefully considered judgment, the most enlightened and accurate interpretation of Jewish law. It is all too easy to dismiss the entire subject of legalized abortion, as so many holier-than-thou religious leaders do, under the ominous heading of "sin." I believe that such spineless and irrational subservience to the dogmatism of theologians who speculate with fine detachment upon such matters in their cloistered ivory towers, is unbecoming the rational and largely moral society of a great nation. In truth, the civilized mind would be hard put to devise a greater sin than to condemn a helpless infant to the twilight world of the slum or the orphanage—which is where most of the unwanted and illegitimate children end up—or to sentence two parents to a life term of caring for, yes, and loving an unwelcome child who is the bitter, unsought fruit of careless rapture, a living symbol of shame, frustration, or even an enforced marriage. If there is to be any talk of sin, then by Heaven, here is where it may be found.

We live in an age when scientists who are quite properly more concerned about sustaining life on this planet than in the conquest of outer space are profoundly disturbed about the economic and social consequences of the fantastic population explosion. At the present rate of increase, our global population will double by the year 2000, and reach the staggering dimensions of four times that number 70 years thereafter. In the most impoverished areas of the world, the help that we are extending to raise the standards of living is more than offset by the incredible rise in the number of mouths that have to be fed. Considering the fact that hunger and bloody revolution are historic allies it is becoming crystal clear that the unduplicated multiplication of the world's population represents a danger to humanity second only to the uncontrolled spread of nuclear weapons.

At a time such as this, when all thinking citizens recognize that human reproduction must be checked if the earth is to be kept safe for humanity, and that it must be done voluntarily, or it will surely be done by famine, revolution and war—at such a time we are confronted right here in our own country with the ironic spectacle of a continuing battle against the legalization of abortion and an enlightened program of public education and aid in the use of contraceptive methods whose sole purpose is to reduce illegitimacy and the tragedy of rejected children—and all in the name of religion and morality. I say to you, dear friends, that there is no agency, religious or political, that is wise enough, or has the right to point a self-righteous finger at some poor woman and order her to bring an unwanted life into this crowded, difficult, and dangerous world.

It is high time indeed that we began to ask certain very vital questions of ourselves and the leaders of our state and federal governments. By what right did the state legislature enact laws infringing upon the privilege of the citizens in a free society to secure surgical help for abortion and contraception counsel when such aid is needed? Why do fearful politicians still continue to steer clear of this sacred cow, in the face of the mounting tragedy of unwanted, unloved and even abnormal children? Is it not time that we matured sufficiently as a people to assert once and for all that the sexual relations of human beings and their reproductive consequences are not the business of the state, but rather free decisions to be made by free people?

Let us, of the Association for the Study of Abortion, raise these and other related questions that have been swept under the rug for such a long time. Let us demand straight answers, and resolve that the crying needs of the millions who agonize over such pressing personal problems, will soon be met by the leaders and legislators of our land who have been motivated by an aroused citizenry.

In my humble opinion, religion, in the highest sense, calls upon each of us to disavow the old taboos that suggest that abortion and planned parenthood are sinful, and assert honestly and proudly that, as creative partners of God, we reserve the right to create families purposefully and joyfully, not accidentally and reluctantly.

Let us help to build a world in which no human being enters life unwanted and unloved; where poverty and hunger have disappeared; where disease is rare, and death seldom premature; where there is adventure for the young and security for the old; where the entire human family, abandoning the evil habit of mutual suspicion and slaughter, has become one cooperative race of man, achieving through unity conquests over both nature and the darker side of human passions, rejoicing in the exercise and fruit of man's creative genius!

THE STATE OF THE ABORTION QUESTION

(By Mr. ROBERT F. DRINAN)

On March 11, 1970 the State of Hawaii became the first government in the English-speaking world to eliminate all criminal sanctions from its laws for any abortion done by licensed physicians. The 50 percent of Hawaii's population who are Roman Catholic constituted the only organized resistance to the change in the abortion laws. Although several legislators who are Catholic voted for the repeal of the abortion law, the Hawaii *Catholic Herald* newspaper in its February 27 issue editorialized that "a veto is the only course of action open to the Governor which would remove this cloud of shame hanging over Hawaii."

At least one Catholic legislator who voted for the change in the law expressed his disapproval of the campaign of Catholic spokesmen. Governor John A. Burns, a devout Catholic allowed the bill to become law without his signature and with the simple statement that abortion is "a matter of individual conscience."

The example of Hawaii will no doubt accelerate the demands for a "non-law" on abortion now being made in virtually all of the states. New York is moving in that direction as this is written. Indeed it seems fair to say that after Hawaii the dilemma confronting Catholics and others opposed to abortion on moral grounds is no longer whether Catholics can denounce abortion, control the votes and thereby seek to prevent any change in existing abortion laws. The real dilemma for opponents of abortion seems to come to this: Is it better to allow the state to establish by law a limited number of reasons which would justify an abortion or would it be better if the law were silent about abortion and thus left this matter to the good conscience of parents and physicians?

This observer feels that the laws enacted in some twelve states over the past three years authorizing abortions where the pregnancy results from rape or incest, where it may injure the physical or mental health of the mother or where the fetus is predictively defective will not solve the problem of abortion. These laws will, in addition, give to the state for the first time in the history of Anglo-American jurisprudence the right to decide which unhealthy or inconvenient unborn persons may be extinguished before birth. Empirical data, moreover, from the several states which have adopted a "liberalized" law on abortion do not give one the feeling that these laws are a happy accommodation between groups which are opposed to all abortions as immoral and those individuals who feel that a certain limited number of social, medical or psychiatric indications should justify an abortion.

Persons opposed to abortion on moral grounds can, of course, still hope for the enactment of a law which predictively would minimize the number of fetal deaths. But should this hope or desire be the sole determinant in judging the wisdom or effectiveness of an abortion law? A further question, moreover, must be asked: Even if the "liberalized" law now enacted in some twelve states does in fact result in fewer abortions than the "non-law" of Hawaii, how can one measure that result against the fact that the government now possesses the right to establish standards as to who may live and who may die?

No one pretends, of course, that it is an easy thing for Catholics and others who believe in the inviolability of fetal life to acquiesce in the withdrawal of criminal penalties against those who would destroy this fetal life. But the question is no longer the possibility of a total prohibition of abortion but rather the question of weighing the long-range evil effects of permitting the government to establish standards as to who will live and who will die rather than simply having the government withdraw from the area of protecting the first twelve to twenty weeks of non-viable fetal life.

If the state of the abortion question after Hawaii poses much more clearly the only two options left for opponents of abortion, it also should bring about a clarification of the credibility of official Catholic spokesmen who in every state of the union have denounced any change in the abortion laws. No one, of course, disputes the right of a Catholic prelate to speak out about the morality of any question. But one wonders whether Catholic clerical spokesmen at the highest level will continue to intervene in the political order and state dogmatically that no change whatsoever in the abortion laws can be morally permissible. One wonders whether Catholic episcopal spokesmen will continue to assume that they can make up the mind of Catholic legislators on the abortion question just as the bishops of Massachusetts in 1948 "told" Catholic legislators not to repeal the anti-birth control law or Catholic officials in New York State not to permit divorce until the very recent past not to permit divorce for the ordinary reasons for which divorce was obtainable in every other state in the union.

Perhaps it is time that all of us recall the words of Vatican II's declaration on religious freedom which urged that "in spreading religious faith and in introducing religious practices, everyone ought at all times to refrain from any manner of coercion which might seem to carry a hint of coercion or of a kind of persuasion that would be dishonorable or unworthy . . . On the assumption that belief in the inviolability of non-viable fetal life is *de facto* a religious belief, can Catholic spokesmen be open to the accusation that they are acting in the abortion controversy in a way which clearly might seem to carry a hint of coercion"?

The limited jurisprudential options now available to those who are opposed on moral grounds to abortion offer at best a Hobson's choice. A request by a healthy mother for the abortion of a healthy fetus is all too often, in Princeton theological professor Paul Ramsey's phrase, "fetal euthanasia."

The consequences to morality, however, of a change in the abortion laws should not blind Catholic spokesmen to the other unfortunate results of their intervention in the political order.

In June 1968 this author in an address to the Catholic Theological Society of America, made a recommendation as follows:

It is submitted that episcopal statements going beyond the morality of abortion and entering into the question of jurisprudence or the best legal arrangement are inappropriate intrusions in a pluralistic society by an ecclesiastical official who wrongly assumes that he can pronounce a moral and uniform position for his church on a legal-political question.

This recommendation is now more relevant and more urgent after the action by the Hawaii Legislature to repeal all criminal sanctions against abortions done by licensed physicians.

ABORTION RESOLUTIONS

RELIGIOUS

Unitarian Universalist Association (May 1968).
American Baptist Convention (June 1968)
United Methodist Church (April 1970).
United Presbyterian Church (August 1970)
Lutheran Church in America (June 1970).
American Friends Service Committee (October 1969).
United Church Board for Homeland Ministries of the United Church of Christ (April 1970).

MEDICAL

American Public Health Association (December 1968)
American Medical Women's Association (November 1969)
American Psychiatric Association (December 1969).
New York Academy of Medicine (December 1969)
American Protestant Hospital Association (March 1970).
American Medical Association (June 1970)
National Council of Obstetricians & Gynecologists (June 1970).
American Psychoanalytic Association (May 1970).
Medical Committee for Human Rights (1967).
Student American Medical Association (1970).

OTHER

Citizens Advisory Council on Status of Women (April 1968)
Planned Parenthood Association (November 1968).
American Ethical Union (January 1969).
American Psychological Association (1969).
National Council of Women of the United States (October 1969)
YWCA (April 1970).
Chicago Child Care Society (1970).
The Izaak Walton League of America (July 1970).
American Society of Mammalogists (June 1970).
American Civil Liberties Union (March 1968).

Senator PACKWOOD. Now, Mr. Chairman, I have obviously been at this subject for a long period of time. I was familiar with it in the Oregon legislature when I served there, although Oregon was not at that time one of the four legalized abortion States that were legal before *Roe v. Wade*.

So in Oregon, while we had a limited right of abortion, it was very limited. We did not have the legal status for abortions that the States of Washington or New York or Hawaii did.

In the State of Oregon, there was a women, Dr. Ruth Barnett, who would perform abortions illegally. The *Oregonian*, our largest daily newspaper, reported that about 75 percent of Dr. Barnett's patients were referred by other physicians, including some of the leading gynecologists and obstetricians then practicing in Oregon.

In the many years of her practice, her clinic was raided several times, and she was arrested repeatedly. At the age of 74 and suffering from cancer, she was sentenced to serve 15 years in the Oregon penitentiary. And while I am sure many people would condemn Dr. Barnett for performing illegal abortions, she did it in part to fulfill what she said was a very real need for women to have access to safe abortions. And I will emphasize again that many of the leading obstetricians and gynecologists in Oregon would refer patients to her for abortions.

Upon her release from the penitentiary after serving part of her sentence, Dr. Barnett wrote a book called *They Weep on my Doorstep*. This book is an excellent history of the dilemma faced by the medical profession before *Roe v. Wade*.

Mr. Chairman, I would like to request that a copy of *They Weep on my Doorstep* be printed in the record.

Senator METZENBAUM. The entire book?

Senator PACKWOOD. It is a small book, a thin book. It is barely the length of some of the statements that we make before this committee.

Senator METZENBAUM. It will be included.

[Excerpts from the document referred to follows:]

THEY WEEP ON MY DOORSTEP

By

RUTH BARNETT

As Told to Doug Baker

HALO PUBLISHERS EDITION

1st Printing.....January, 1969

CHAPTER ONE

Pregnant.

The word is alive with many meanings.

To know you are pregnant can fill your cup with joy. And to know that another life quickens in your womb can, in different circumstances, fill your heart with anguish and dread.

I know, because I have known both kinds of pregnancies.

In my 74 years of living, I have learned to keep many secrets. And I have learned to keep them well.

But I have lived too long to keep my own, personal secrets. The evening of life is a good time for reflection and for confession. So, I am going to tell you something which for most of my long, full life I never told to mother, father, husband, or even to closest friend:

The first abortion of which I ever had any experience was my own.

It was a long time ago, but a woman does not forget the details of such an experience. His name was Frank. It all began casually enough, in the same way as half a dozen other dates except, perhaps, for one thing. Frank was older. He was 19 and I, 16. He was tall, energetic, full of talk about his future as an engineer, hinting at his prowess as a "ladies' man." And he was so handsome.

What more shall I try to recall? In the years since I first realized I was pregnant without being married, I have talked with and helped hundreds of girls who have had the same experience. With each it was much the same—a devastating, almost unbelievable nightmare of doubt and fear. With each of them it was singularly personal, as it must be. For each girl, it was her trouble and hers alone. Always there was the wrenching from what they knew was secure and right. And always, in talking with these girls, I could not help but remember my own feelings long ago.

As I look back, I wonder what I saw in Frank. He was neither a romantic, nor a rogue. Just an average youth, careless, thoughtless, ignorant perhaps; but so was I. I cannot, now, hold him to blame for what happened. But at the time, I did.

When I told him of my pregnancy, he was sympathetic at first, then resentful. He was not to blame, he said. What kind of a little fool had I been to be so careless?

"What are you bawling about? You can do something about it," he said.

When I tearfully asked him what and how and where, he shouted, "How should I know? That's for you to find out. You got yourself that way, now get yourself out of it." Seeing the look of amazement on my face, he added a thrust that I've heard second-hand a thousand times since. "How do I know I'm responsible anyway? You've been going around with other guys."

I was too stunned to reply. He turned and hurried away. I never saw him again.

In the years that followed, I have observed many "Franks." Some of them came to my waiting room—as a general rule, unwillingly—accompanying their partners-in-trouble. Others, who had fled, as my Frank had, were described in familiar detail. For years I hated Frank. So it was no surprise to me to find many of my patients had the same implacable hatred for the man responsible. I did not blame them, but would often try, sometimes successfully, to talk them into a reconciliation—indeed, sometimes, marriage.

In my own case, there were plenty of worries besides the boy's irresponsibility. I became ill and lost weight rapidly. Morning nausea was a double problem—suffering through it and trying to keep mother from guessing its cause. Fortunately for both of us, she did not suspect pregnancy. Eventually, she diagnosed my illness as possibly being due to a malfunctioning appendix. She wanted me to consult our family physician, the last person I cared to see. I managed to avoid this confrontation. I knew, in a vague sort of way, that there were doctors in Portland who could have "done something" for a fee, but I had no idea how to find one. I did not know the word, abortion, nor what it was a doctor did. Nor did I have the faintest notion of what the cost would be, let alone how I would pay for it.

When I began making the notes for this book, a friend with whom I discussed the project asked me if my own pregnancy as a young girl had had anything to do with my becoming an abortionist and making it my life's work. The question was so naive, it took me a bit aback. "It had everything to do with it," I answered.

After nearly half a century of helping girls and women in trouble, I have no doubts at all about why I first became interested in the career that has brought me so much joy along with a full measure of grief.

But at the time of my own little tragedy I had no idea that my admiration for the man who helped me and others like him would lead me to my life's vocation.

And I had no idea then that I would ever share my secret for all to read. I have so often told my adorable granddaughter: "A still tongue makes a wise brain."

As she, along with you, reads this book, she will understand why my time for such secrets is past.

fair. There were bouquets of flowers from the greenhouse at at the men's prison. It wasn't too bad.

On Saturday, March 9, there was a major riot at the men's prison. My room in the west wing faced the wall and at 3 o'clock in the morning I could look out the window and see the flames shooting up. I counted 15 yellow raincoats which I took to be state policemen.

There were only two matrons on duty on Saturdays and the girls were nervous and muttering. Quite a few of them had been arrested with their "old men" and those "old men" were in the regular prison and they were concerned about them. I was playing Scrabble when we first heard about it and one of them said to me, "Maybe we should riot a little." I said, "You will not." But the girls were upset and nervous, so the matrons decided to let them dance. Ordinarily, dancing is forbidden because they don't want the girls to have body contact. But the girls danced that night and Trina, the big black woman, went to the kitchen and made a big batch of popcorn. We got through the riot without any real trouble in the women's prison.

During the five and one-half months I was in the penitentiary a lot of good people on the outside were petitioning the parole board to consider my release. They raised the question of my age and the cancer of my legs. The parole board apparently shared the view of these persons that my imprisonment wasn't of any great value to the people of Oregon. On July 1, 1968, I went before those five solemn men.

They asked me some preliminary questions and then one of the men on the board asked me what was one of the most difficult questions ever put to me: "Would you do me a favor and promise me you will never do another abortion?" is what he asked.

"Never?" I said. "Never is a long, long time. I'm never going to prison again for somebody else's delinquency."

"You were delinquent," he said.

"I was delinquent for 50 years," I said. But I could tell by the way he looked at me that I was either going to give him the right answer or I was going to be in prison a lot longer. It was no time for argument, no time for any discussion of

the rights and wrongs of abortion. It was my moment of truth and if I didn't handle it rightly I could well die in that jail.

He put the question again. "Would you promise me, Ruth? You're so well known that if you start operating again it would let us down."

I looked him right in the eye and I said, "I give you my sacred word of honor as a lady I'll never do another abortion."

"That's all we want," he said.

My heart jumped and I asked the board if I could get out for the fourth of July. But it wasn't that easy. There was a matter of paying a $5,000 fine adjudged in one of the cases and other technicalities. I was finally released on July 15.

So, I came home to my grandchildren and my dogs. I spend my days like a lot of other grandmothers, except that I manage to do a lot of fishing. Not long ago we put nearly 500 pounds of tuna into our boat. There are still new thrills in life for me, even though I've reached my 75th birthday.

After 50 years living "outside" an unjust law, I now live within that law, as I promised the parole board I would. But while I keep my promise, I cannot alter my thinking about a law that I think belongs in the dustbin of history. Some day, with your help, such laws will be no more than past reminders of man's bottomless stupidity and monumental inertia in the face of social progress.

At 75, I cannot hope to see universal abortion law reform. But already, I see a glimmer of light and a bright hope for a better world for the woman of an enlightened tomorrow.

and after a few days one of the matrons brought me a pair of tennis shoes. I washed them inside and out with shampoo soap and cleaned the shoe laces with Bon Ami and they weren't at all bad.

That first day there was wonderful food to eat and I soon learned that the 51 women with whom I shared the prison ate well every day. We had spaghetti and meatballs the very first day and salad and chocolate pie and cornbread and hot biscuits. There were pancakes every morning. No wonder nearly all the inmates had big bottoms!

The second day I had my X-rays and a lot of vaccinations and innoculations. They gave me shots for polio, diphtheria, flu and tetanus and I got a terrible reaction. I was feverish for six days. I just lay in bed and read a little. Three mornings I was too sick to take the compulsory shower. Before the fever broke I lost 13 pounds.

But after those six dreadful days, it wasn't at all bad. My 51 fellow inmates were all kind to me and the matrons were nice to everybody. The girls would grab my tray at mealtimes and help me with it because of my cane. We were all sisters under the skin.

Each girl has a private room, about nine feet by 10 feet. They are designed so that there are no bars showing anywhere, just cottage windows. There is a birch door with a little glass spyhole so the matrons can look in.

After a while I wrote in my diary, "If I could just sleep nights, everything would be jake. Time doesn't worry me. The days fly by. I paid a couple of thousand dollars one time to send my daughter to a luxury place in California to lose weight—this beats it all over."

Another day I wrote: "The ducks and geese fly over and I wonder why the guard in the tower doesn't take a shot at them. He sits up there all day and I wonder if he has a grudge against the world or just against himself."

While I spent my days cleaning my room—I used a rag on the end of my cane to clean under the bed—and reading Frank Yerby and Phillip Wylie novels—life went on in the outside world. My Marine grandson was hit by shrapnel in Vietnam, two of his best buddies blown up right beside him. They

brought him to the states and my granddaughter Ruthie and her husband went down to California to see him. Ruthie wrote me every other day and one day there was other bad news—my little Yorkie, Tiger, had been run over and killed. That really hit me and I had a couple of very bad days and nights.

And then there were the days when Martin Luther King was killed and when Bobby Kennedy was killed. They let us watch the funerals on television and it was sad. And it was sad when some of the girls were discharged and they left with nobody to pick them up and hardly anything in the way of clothes. They seemed terribly lonely to me.

Several of the inmates were particularly kind to me. There was a huge black woman I'll call "Trina" who fixed me nice trays and smuggled me oranges from the kitchen. She was in for bad check charges. She was one of the two inmates who always called me, "Doctor." When I was finally discharged she couldn't bear to watch me leave.

And there was a girl I'll call "Betty" who did my ironing for me. It hurt me to do my own dresses. There was a pathetic girl who looked like a schoolteacher. She had put her baby in a bathtub and slit its throat. Her other children saw her, so she killed them, too. She has been in and out of the State hospital as insane and is serving a life sentence. There was a very quiet girl working in the kitchen who was a girl friend of a girl who had killed her children.

Of all the things that happened while I was at Salem, I think one of the most amusing was when the girls found out about my using shoe polish from the commissary on my hair. I was allergic to hair dyes and the polish worked beautifully. When the girls found out about it they laughed uproariously and the next morning I found a note shoved under my door:

"Ruth, my dear. . . . What brings you here? . . . A law we must abolish . . . But I do quite well . . . So, what the hell . . . With my cane and a can of polish."

And so the months went by with clean sheets once a week, clean towels twice a week, lots of Scrabble games and a number of the girls taking the Upward Bound classes in the north wing. The matrons were capable and strict for discipline, but

There were, again, months of legal jousting. This time I hired Charles E. Raymond as my attorney. Formerly a district attorney he had played a role in harassing me. Now, he was to become my defender. He was a Catholic and a fine man versed in the subtleties of legal in-fighting. Like so many of the people who played major roles in my life story he, too, has gone on to join what Mark Twain has called "the majority."

Right after the 1956 raid, I closed down the Slim-U Clinic in the Alderway Building. Throughout 1957 and into the first few months of 1958 Raymond fought against the new indictments. The legal maneuvering seemed interminable. As fast as we would knock down one charge, the district attorney's office would come up with new charges. Finally, in March of 1958, my receptionist and I withdrew our earlier pleas of innocent to a fresh charge of manslaughter by abortion and entered pleas of guilty. Once again I went before Judge Bain for sentencing. This time he gave me a stiffer jolt—one year in the county jail at Rocky Butte. My receptionist was given a sentence of six months.

A few days later I was again a guest of Multnomah County at "Sunshine Terrace." Except that I was to be there 10 months in all (with time off for good behavior) instead of the four months I had spent there in 1954, jail life was not much different. Again, Superintendent Matthews was kind to me and the other women inmates. Again there was the weary soul-desroying drudgery. Again I tried hard to keep my spirits up by making a game of it.

There were only a few bright moments in those ten long months. Once Superintendent Matthews took me out of jail to a dentist on N.E. Sandy Boulevard to have some dental work done. I guess that's what started more rumors that I could come and go as I pleased. I wish such had been the case.

But the ten months finally came to an end and I was free once again. You might think that this time, for good and all, I would have given up my abortion practice. I had twice been to jail and had been stripped of my license to practice. I faced serious penalties if ever arrested again. I had no clinic and little chance of renting office space in Portland for a new clinic because of the resentment felt toward me by a part of the community.

What did I do in 1959 when I was released a second time from that grim rock-walled prison at Rocky Butte? I did what I had been doing for more than 40 years. I went back to work, doing what I knew best—helping women in trouble.

EPILOGUE

It has been nearly 18 months since I wrote what I thought was the last line of this book. In some ways, I wish that the book could have ended with that unhappy yet proud declaration that I would continue to care for those who came to weep on my doorstep. But such was not to be.

On February 5, 1968, I entered the Oregon women's penitentiary to begin serving a two-year sentence on charges of manslaughter by abortion. My attorney had exhausted his appeals to the Oregon Supreme Court and there was nothing left for me but to make the best of it. I had thought that my physical condition might win me another stay of sentence, but the law is remorseless. At 74, I was the oldest woman ever incarcerated by the State of Oregon.

I am not going to tell you that I enjoyed my first (and last!) sojourn in the Beaver State's modern correctional institution for women. On the other hand, I'm not going to tell you that it was any nightmare, either. In all truth, it is the finest place that any such institution can be. It has been dubbed Oregon's "country club" and the nickname is not a cruel joke, but a tribute to a really excellent penal facility.

Country club or not, prison is still prison. When I arrived I had to surrender even the few things I had brought with me. They took my wig and my false eyelashes and had me take a shower. A man took my fingerprints. My fingers went crack, crack, crack, as he rolled them over the inky form. "My you have lots of arthritis," he said.

They gave me an almost unbelievable cotton nightie. I hadn't seen one like it since I was a girl in Hood River. One of the matrons gave me a little sample lipstick to do me until I could buy one at the commissary later in the week.

They brought me a uniform with a Peter Pan collar and a big pair of ugly Buster Brown shoes. I couldn't bear the shoes

CHAPTER EIGHTEEN

Time and time again I have vowed never again to perform an abortion. And each time my resolve has been broken down by those who have come to weep at my doorstep.

So it was in 1954 when I came out of jail. Friends, lawyers, associates all hammered at me with the idea that I was under a probationary sentence and that if I were caught and convicted of another breach of Oregon's abortion laws I would face a much stiffer jail sentence. They reminded me that I was no longer a young woman and even I—one who had fibbed about her age for so long she wasn't sure just how old she was—was aware that I had reached the August of my life. Like Emily Dickinson, I was fearful "lest this little brook of life some burning noon may go dry."

Former patients, many of them frantic, continued to importune me. My insistence that I had "retired" was met by tearful objections and entreaties for the names of other abortionists.

Sadly, I could not tell them "where to go." The same crusading newspapermen who had caused my arrests had closed down other abortion clinics. The few that remained in the Northwest were "underground." Inevitably, I began "sneaking" cases. At first I took only the most desperate women with the most serious problems. But as the months went by I took more and more cases, practicing as much discretion as was possible.

My associates at the clinic were past masters of discretion. The woman who booked the patients, for instance, never allowed a patient to come to the clinic and be operated on the same day. And she developed a clever interview technique which made it possible to screen out those informers merely intent on entrapping me again.

If a woman said she had come from California by airplane, for example, my receptionist would ask her the time and number of her flight. It took only one simple telephone call to confirm that there was such a flight scheduled by the airlines. Other questions and the answers she received to them helped to buttress or destroy a potential patient's story.

There was a real need for such cloak-and-dagger precautions in the months after my release from jail. Periodically, while driving to an appointment or going shopping, I had the feeling of being followed. Several times, while walking, I was certain that a man or woman was shadowing me. There were strange telephone calls at odd hours from people whose stories didn't add up. And there were the occasional visits from candid reporters who would say, "Come on now, give us the low-down on what you're doing."

I met such queries with general remarks about my retirement. But always there would be a skeptical look.

Eventually, the feeling of being followed and observed, like the visits from newspapermen, tapered off. I had ceased to be big news. The public lost interest in a mild-mannered grandmother who, to all intents and purposes, was busy finishing a book of memoirs and doing research on a social problem.

However, as my practice grew once more to large proportions it was inevitable, looking back, that I should be raided again. It happened in November of 1956 when a policewoman, posing as a "patient" managed, after three weeks of pleading and a trumped-up story about attempting to induce her own abortion, to get by my security screen and into my operating room. Once inside, she identified herself as a police "plant" and began screaming to a raiding party of police and medical examiners outside.

The events that followed were like a repeat performance of the soap opera played out a few years before. Dr. Helfrich, my receptionist and I were charged with conspiring to commit an abortion on the policewoman. The charges against Dr. Helfrich were later dropped for want of evidence. The physician had never played any role in my abortion practice.

driving were exhausting. Earl took a hot bath and went to sleep. I lay awake, restless and fearful of what the next day would bring.

Vancouver, Washington lies just across the Columbia River from Portland. After a few hours rest we drove across the Interstate Bridge and directly to the Multnomah County Jail, stopping only once to telephone my attorney.

While an officer at the courthouse took my name and address, the room began filling up with people. Although Saturday is usually a quiet day, word of my arrival to turn myself in got around quickly. Reporters and photographers appeared as out of nowhere and were soon buzzing around us.

A uniformed officer stopped by the desk and said, apologetically, "Dr. Barnett, I'd rather have been anywhere else in the world than in your office yesterday." Then, the flashbulbs started popping and the reporters began their questions. My attorney, said, "No comment."

The staff gave me a step-by-step account, from the moment the police had swarmed into the building and told the elevator operator to touch nothing but the control lever. Several days later she was still wondering what else there might have been to touch. We had no secret alarm bells or electric buzzers. Why should we have had any alarm system when we had operated for so many years free of any trouble with the law?

The raiding procedure must have been adapted from a "B" grade movie. Sixteen people had charged in to arrest the three of them. They were loud and abusive. Women in the waiting room, guilty of no offense, were treated harshly. Those in the dressing rooms were terrified. One newspaper reported a woman behind a curtain, in an adjoining room, struggling desperately to get dressed.

The raiders ransacked the offices without a proper search warrant, yanked drawers out of desks and cabinets and spilled their contents on the floor. They confiscated unopened mail, a file of paid bills and current bills. They took several hundred dollars in cash—never returned to this day—that was kept on hand for operating expenses and salaries. One deputy, who must have been a fan of Sax Rohmer's Fu Manchu stories, was certain that the hand-carved Chinese desk contained secret drawers and panels. When he couldn't find them, he threatened to smash the desk, but desisted when the receptionist protested vigorously.

Looking back, I believe they were looking for a filing system they could bundle up and cart away: a list of patients together with the names of doctors who had sent them to us. But the identities of those who came to us for help were well hidden. There was no such file.

They scooped up every instrument they could find, no matter what the design or purpose. And, it was in this connection that their thirst for melodrama was finally satisfied. There was an ornamental grille installed beneath a window, to hide an unsightly heating arrangement. It was equipped with knobs or handles that were clearly visible and easily grasped. Behind the grille, a detective found several packages of instruments. Flashbulbs popped again. Here was a secret cache!

Those instruments were the onetime property of the late Dr. Stewart, former owner of the clinic who had left them behind when I bought the practice. He had discarded them for new and better instruments. They were almost antiques, a type used at the turn of the century. They might have been of interest as rusty museum pieces, but certainly had no value in modern surgery. We stored them back of the "secret" panel to get them out of the way. Surgical instruments are not as disposable as paper towels. There is always the possibility they will be removed from a trash can or be purchased from a second-hand store and then be used by an untrained, unskilled person. Behind the grille had seemed to us the best place for them.

After the raid, the staff was held in the courthouse for hours and questioned at length before being allowed to use a telephone. Bail had been arranged in the closing minutes of the business day.

"We'll fight this," I told them. "We'll have the best legal advice I can get."

Before there could be an indictment, there had to be evidence. In all my years of practice, no one had ever gone—or had cause to go—to the law enforcement people with a complaint. Now, it seemed, there was evidence to present to a grand jury. Somebody had talked. But who and about what?

As we drove along, I began to realize how little I knew of the Oregon laws pertaining to abortion. They had never really interested me until that terrible day. The state statute, written in 1864, about the same time legislation had also been enacted making it illegal for a person to become a doctor merely by hanging out a shingle, had remained virtually unchanged. That much I knew. But I had never concerned myself with the exact wording of that statute. For that matter, neither had the doctors who referred their desperate patients to me, nor any of the previous district attorneys of Oregon.

This is not as strange as it may sound. My clinic had been in existence for more than sixty-five years in various locations, under various ownerships. In all that time there was no attempt to halt its operations. This was not because hush money had been spread around. Neither I nor my predecessors had ever paid or been asked to pay for the privilege of operating.

Portland was, perhaps, unique in this respect. The duly elected officers of the law, members of the medical profession and state medical board knew we were in business. Trying to conceal the clinic, or its purpose, would have been as impossible as hiding an elephant in the parlor. Thousands of women had passed through our doors, of all colors, races and creeds and from various walks of life. The archaic statute had never been considered.

Why now, I wondered, had we been raided? Earl and I rode in silence most of the time, speaking suddenly only to punctuate a private, troubled thought, such as his wry comment: "Maybe blackmail's a good investment."

About 1 a.m. we reached Pendleton, the Round-Up city, where we stopped long enough to buy the late-edition Portland newspapers. Then we continued homeward. I turned on the map light and saw my name in big black headlines for the first time in my life.

"How bad is it?" Earl asked.

It was a few moments before I could answer him. "Worse than I ever imagined," I said.

Here was my life's work vilified and smeared. I had long believed that every woman has the right of abortion if she believes it necessary. How could I believe otherwise after

talking to thousands of women—sick, lame, frightened, and hungry—in need of help. I had worked hard to make my establishment a beautiful and friendly place, where every possible safeguard was taken against infection and accident. And where—most important of all—none need fear that today's secret would become tomorrow's idle gossip.

I was proud of the clinic and justly so.

And now the newspapers made it appear something between a plush-lined house of ill-fame and an abattoir catering specially to the young. "Several young women, one of high school age, were in the waiting room. One, apparently fearing arrest, ran screaming down the stairs," a newspaper reported. The dressing rooms and surgery were described as though the reporter had viewed them in some kind of private hallucination. Out of his welter of words emerged an image of dumb cattle waiting to be slaughtered by a sadistic butcher. All my years of work for hapless women had been drowned in a torrent of newspaper sensationalism.

We were a few blocks from the Columbia River ferry that would take us into the state of Washington when Earl stopped in front of a small all-night cafe. The parking lot was quiet and dark. Through the lighted window I could see the clock on the wall. It was 3 a.m. We went in, sat down at one end of the horseshoe counter. We were the only customers, but not for long.

Headlights flashed through the windows as a state police car drove up and parked beside ours. Two officers emerged. One went to the rear of Earl's car, took a slip of paper from his pocket and beamed his flashlight on the license plate, as I watched through the window. It seemed an eternity before he shook his head. They were looking for my license number, not Earl's.

The officers came into the cafe and sat down at the other end of the counter, opposite us. They looked us over casually. Earl finished his coffee, paid the check and we walked out as slowly and nonchalantly as we could.

In a few minutes we were on the ferry, heading for the Washington shore. By 6 a.m. we reached the Evergreen Hotel in Vancouver, Washington. Fourteen hours of high-speed

a dress and warm coat for the woodcutter. But my greatest satisfaction was my belief that I had saved her from possible death from infection.

Some years ago, my husband, Earl Bush, and I had a house guest at our Eastern Oregon ranch. She was a stunning, prematurely gray woman with whom we were laughingly reminiscing when she turned to me and said:

"Do you remember, Ruth, the time I came to you and you took care of me?"

I said I did and she recalled that she had been secretary to the governor of Oregon when she had missed a couple of periods. She had mentioned it to an intimate friend, a physician who didn't bother to examine her, merely pooh-poohed the idea that she could be pregnant. "An early change of life," he had called it.

"You know, Ruth," she said. "When the morning sickness hit me, I nearly jumped out of my hotel room window. But then I thought of you.

"The next day I was back at my desk in Salem and up to my eyebrows in a tough political campaign. Nobody was any the wiser—not even the governor."

Several years before the Portland crack-down on abortions, San Francisco went through similar turmoil. Many San Francisco women then came to me.

CHAPTER TWELVE

"Ready with Portland," the operator said.

"Margaret," I asked, "are you all right?"

"I'm fine," said my daughter, "but you're in trouble."

The clinic had been raided—the last thing I expected. True, there had been rumors, rumblings and whispers for weeks. But before leaving for the holiday, I learned from what the newspapers term an "authoritative source" that no legal action was contemplated against me. This, in effect, was a reaffirmation of the unwritten agreement under which I had always run my clinics: No prosecution, unless there was a death.

"There's a warrant out for your arrest," Margaret said.

A raiding party of sixteen including the sheriff, city police officers, a special investigator for the D.A., a lawyer on the D.A.'s staff, newspaper reporter and photographer had stormed into the office.

"A big, Hollywood-type production," she said. "Brave lads in blue stomping up and down, flash-bulbs poppin'. They even had a hospital alerted, and an ambulance standing by, in case they found a patient on the table."

The receptionist, nurse and doctor who worked for me had been arrested and taken to the Multnomah County courthouse. They were still there, as far as Margaret knew, being held incommunicado.

"That's only the beginning," she continued. "They've been out to our house and are looking for you everywhere. They've been talking about you on the police radio, looking for your car. They've got roadblocks out."

CHAPTER NINE

In the movies, they always depict the fallen woman sneaking up a dirty, rickety stairway to a dismal room—or making her way, furtively, into a dark alley that leads to a decrepit shack where some alcoholic doctor or untutored butcher performs the abortion.

A clinic such as mine was not that way at all. It was a bright, cheerful place where women's problems were handled quickly, efficiently and with dignity, no matter what the circumstances of the patient.

I do not honestly know how many abortions I have performed in the half century I have made this work my profession. Certainly, they run into the thousands. It has been suggested that I have done as many as 40,000 such operations since 1918. The figure sounds high, but it is quite possible.

And there is one figure of which I am entirely certain. In all those abortions over all those years, I never lost a single patient.

I have heard a number of physicians say that no one can perform as many abortions as I have done without losing a patient. They talk about the dangers of rupturing or perforating a womb and the ever-present danger of hemmorrhage.

These doctors, whose knowledge of abortion techniques is miniscule at best, are talking through their hats. I have a light touch and I have never perforated a uterus.

I can recall, over the years, eight or nine, perhaps ten cases, in which there was serious bleeding. Each of these cases I sent to a hospital, primarily for the patient's peace of mind. I could have dealt with the hemorrhage, but thought it best, all things considered, for the woman to have hospital treatment.

Patients who came to my clinics were sometimes violently

ill when they arrived. I've had husbands bring their wives to me so sick they had to be carried into my office.

Sometimes, a woman with a difficult pregnancy suffers from pernicious vomiting. They are so ridden with nausea they cannot even hold water on their stomachs. Their family doctors would give them an injection or two—and then refer them to me.

The rapid recovery which comes from abortion to a woman suffering in such a way is nothing short of amazing. I remember cases where the woman was too ill to stand. Ten minutes after the operation these women were sipping tea and eating crackers in my clinic's little kitchenette.

The Pullman kitchen in my office lounge was completely equipped and one of my nurses was a wonderful cook. Our luncheons were so tasty we sometimes had as many as eight to ten guests. Not only patients, but business friends as well. Those were times with lots of laughs and good-natured kidding. I accused my nurse of putting out a sign on the street: "Try Barnett's Blue Plate Special."

We dealt with the comic and the tragi-comic. There were elements of amusement in the arrival, one day during World War II, of four uniformed Soviet women officers from a Russian ship berthed at Swan Island for repairs. One was a captain. The four Russian women were accompanied by a Soviet male official who acted as an interpreter to explain their problem—they were pregnant. Apparently, free love, Communist style, was practiced on the Soviet Union's ships.

Unwanted pregnancy is no respecter of persons. Among my patients have been those of fabled wealth and high position. And there have been others who were dirt poor.

A widow came to me who was so desperately poor she was rearing her family of five children by cutting firewood. The man responsible for her sixth pregnancy was married. His Catholic wife refused to consent to a divorce.

Faced with the prospect of six mouths to feed, six bodies to clothe and very little money, she had tried all the home remedies in an effort to miscarry only to become sick and feverish. Before she left the clinic my nurse took her home address. We sent a big box of clothing for the children and

I knew the boy's father by reputation. He was said to be an honest man, stiff-backed, proud and on the prudish side. He had a flaming temper and his verbal explosions were legendary in the retail business. I had a hunch the boy had not confided in him. This hunch was strengthened the next day when I phoned his mother and she agreed to come to my office with her son.

Junior was an uneasy lad, big of hand, big of foot and red of face. If even half of what I heard of his father's temper were true, Junior would certainly be bearing some marks had his father learned of his escapade. The mother was expensively dressed and glacially calm. She had come, she said, to set me straight. She was not going to pay any part of that girl's operation. Her son may have had relations with Polly O'Hara, but that did not make him responsible for her condition. After all, there were other boys in high school, she told me archly.

"What about that, Junior?" I asked. "What's your story?"

"Well I . . ."

"Polly says you were the first and only."

He blushed even redder until his face looked like a brick. "I - - - I guess I am," he stammered.

Junior's mother now made a long speech, shaking her finger at me. Her boy had been led astray. He was much too innocent to realize he had been duped—and on and on. I heard her out . . . the same old excuses and rationalization. One thing caught my attention, however. Her nail polish. It was the same shade of red as the berry stains on Mrs. O'Hara's hands.

When she finally finished, I said, "Perhaps I should discuss this matter with your husband."

I reached for the telephone and began to dial. She hesitated only a moment, then opened her purse. She paid for the operation, the entire amount of $75. Then she left as grandly as she had entered. The boy seemed pleased and, I think, relieved at having met some measure of his responsibility. He looked back at me from the doorway, grinned and clasped his hands together over his head in the manner of a victorious prizefighter.

I never saw the youth again, but some months later, while shopping, I met his parents more formally. They were with a mutual friend. His mother looked frightened when she saw me. Her face was set in severe lines and she looked at me without recognition.

"We've already met," I said when we were introduced, "but for the life of me I can't remember where."

She extended her hand, squeezing my fingers as an expression of gratitude.

Not all husbands have the inclination, time or money for extra-curricular affairs. Some seem to have a surfeit of desire for their legal wives, coupled with a compulsion to inflict pain on them. It was a rare week that did not bring a woman to my office exhibiting evidence of her husband's brutality.

Polio victims came to my clinic in wheel chairs, their bodies so warped and twisted they were unable to lie on the table in normal position. I have operated on some of them with crippled feet resting on my shoulders, the only way it could be done. Nor were casts a novelty. There were patients wearing every known type of cast; some encased from neck to hip, so completely locked in plaster-of-paris that one could not understand how their pregnancies had been accomplished. Many women told me they had to be aborted because they were the wage-earners for the family. The husband had been bedridden for months or years with a broken back, crushed pelvis or similar difficulty. One girl who came to me said she had only $15 for the operation. Her husband, she said, had a "bad back." And yet he had managed to make her pregnant. Some old goats could manage it with one foot in the grave and the other on a banana peel.

CHAPTER SEVEN

The depression of the '30's was still with us when I bought Dr. Van Alstyne's clinic. People had stopped jumping out of windows and the apple salesmen had vanished from the street corners, but unemployment was still a staggering statistic. Money was hard to get and even harder to keep.

A beginning abortionist, like any fledgling medic, has to build a practice. I had by-passed that problem, in part, by purchasing a going practice. But that did not mean that all Dr. Van Alstyne's patients and their friends would flock to me. More important, it did not assure my obtaining any volume of referral work from the medical profession. That was something I had to earn. As a result, there were many slack days when Beatrice and I would sit around waiting for the phone to ring or the door to open. And there were other days when we were so busy we could not find time for luncheon—especially on the weekends.

Those who could not pay the full fee gave whatever they could. An abortionist's fees are based on a length-of-pregnancy scale. When I was with Dr. Griff she charged $25 for women who had missed only one period, $50 for those over their second period and $75 for more difficult cases. It is the same nowadays and there is good reason for such a sliding scale. An early abortion is a relatively simple matter. In a more advanced pregnancy there is always the chance of hemorrhage and this means a great deal more work and responsibility for the doctor.

In those depression days, some women paid nothing. And those who were more affluent were charged somewhat more than the usual fee. I make no apology for this practice. Medical clinics of all kinds are run on the same principles. I chose to charge off any deficit to the memory of a young, quondam dental assistant who, long ago, needed help and found there

were some people who cared. I never forgot my own experience and difficulty in raising the needed money.

Ours was strictly a cash business. A clinic of the traditional sort could send monthly statements, knowing that most of the patients would eventually pay their bills. We had to balance income against overhead daily. Too much charity work would not pay the overhead.

Sometimes, I found myself acting as a bill collector for my patients. There was Polly O'Hara, for instance, a high school girl whose mother brought her to us and whose name I have changed. I heard Polly's story in the consultation room and it was neither new nor startling. She was the oldest of five children. Her father was a construction engineer who had lost his job. A lengthy illness wiped out his savings. He had had to sell his home and move the family to a rented house in a poorer neighborhood.

Polly was rushed by a popular boy in her high school class. His father owned one of Portland's better retail stores. The boy had a car and plenty of pocket money. At the time, he may have believed he was genuinely in love with Polly, or he may have pretended. But the inevitable happened and Polly became pregnant. When she revealed her situation, he wanted to have nothing more to do with her.

Polly told her mother, a wise and sympathetic woman. The mistake had been made and she accepted it, not as a means of chastising her daughter but as a matter for consideration and decision. The next step, to her, was obvious. Abortion. But how to get the money. Fortunately, this was school vacation. Mrs. O'Hara took her five children with her to work in the berry and bean fields. Their small earnings were pooled. Then she brought the money to us.

"I know it's not enough," she said, "but it's all we have."

I told her, "Your daughter didn't get pregnant by herself. That boy certainly shares the responsibility. He shared the pleasure. He should share the costs."

"I know," she said, "but I talked to his mother and they won't help."

"Let me see what I can do."

Senator PACKWOOD. Mr. Chairman, let me indicate what we are trying to do here, so that there is no confusion.

We are not trying to prejudge a whole variety of issues that have not been decided under *Roe v. Wade*. We had great debate when we drafted this as to whether or not we should put in it that this will permit or prohibit sex-selection abortions, or whether it will permit or deny parental consent or parental notification. What we wanted to do was to make this as clean a debate as possible.

We are simply trying to restore the law to what it was after *Roe v. Wade* and before *Webster*, and not attempt to prejudge any other situation. We do not want to allow the very critical issue of should a woman have a right to choose to get mixed up in the kind of debate we had on *Grove City*, where those of us who were trying to change the U.S. Supreme Court's case were accused of trying to extend the law way beyond what the law was prior to *Grove City*. We are not trying to do that.

If this bill passes, all it will do is statutorily guarantee nationwide the rights that a woman had under *Roe v. Wade*—no more, no less. But it does guarantee that if by chance *Roe* is overturned—and I hope that day never comes—if by chance *Roe v. Wade* is overturned, then this statute will guarantee at least statutorily that a woman has the same rights that she now has constitutionally. The statute is not as good a guarantee, but Mr. Chairman, if *Roe v. Wade* is overturned, and we do not have this statute, then what you've seen in Guam, what you've seen in Idaho is going to be repeated hodge-podge throughout the country, some States having legalized abortion, others not; women of wealth being able to fly to the States that have legalized abortion and get a safe abortion; women of poverty not, and they will have botched abortions or illegal abortions, or will have no right to make the choice at all because they can't afford anything.

Mr. Chairman, most desperately, that is what we want to avoid. So I urge this committee to send the bill out so that we might debate it, pass it on the Floor of the Senate and get it over to the House of Representatives.

Thank you.

Senator METZENBAUM. Thank you very much, Senator Packwood. I commend you for your longstanding leadership in this area. You have been at times a voice in the wilderness, but no longer are that. There are any with you.

Senator PACKWOOD. Thank you.

Senator METZENBAUM. Senator Hatch, you did not have an opportunity to make an opening statement. When I made mine, you were not here, so I just went ahead.

Would you care to at this point?

Senator HATCH. If I could, Senator, I would appreciate it.

I can think of no other issue that confronts the Congress or that creates such divisiveness as the legality of abortion. There are strong arguments on both sides of the issue. I choose to be on one side; that is, of restricting abortion except in very limited circumstances. I believe that the right to choose is still there, except that choice is one that should be made prior to becoming pregnant. I think there is a right to choose both ways.

The problem here, Mr. Chairman, is that regardless of what anybody does on this issue, this issue will not gently subside and disappear. This intensity will be reflected in the testimony of our witnesses today who will present their views on S. 1912. They will describe their perception of the legislation's impact on society, the unborn, and the overall debate on human life.

This is a serious issue because there are two million abortions in this country a year. We are the most permissive country in the world, with the possible exception of mainland China, where they have quotas on abortion. And, of those two million, the testimony we have had in the past has indicated that only 1.5 percent may be necessary to save the life of the mother, for rape, incest and/or serious deformity. Many people would not support abortion when there is serious deformity because testimony has been presented which shows that some of those who we were told that a child was seriously deformed was not in fact deformed when he/she was born.

If only 1.5 percent are—and hypothetically let's double it to 3 percent; and that comes from pro-abortion people and researchers—then you are talking out of two million abortions a year, up to 60,000 abortions are performed to save the life of the mother, for rape, incest or serious deformity.

That means that 1,940,000 abortions a year are for reasons of convenience. Now, I don't care who you are, I don't care what side of this issue you are on, that should cause us all concern. And, there is something terribly wrong. The vast majority of people in this country know it, and although many buy this argument of right to choose, the real question is the right to choose what, when and where.

I am also concerned about this hearing, because we have only one witness on the side of those who are pro life, and that particular witness, we have been told by staff of the Majority, cannot show the sonogram evidence that she has until after this hearing is basically over and people have gone.

We did not hear about this restriction on the evidence until this morning, until after the television sets were set up. This is a woman who has had two abortions herself, who I think has some very important sonographic evidence to bring before this committee.

I have never seen an effort to prevent any kind of testimony from either side. When I was chairman, we balanced these hearings. We would have equal numbers of those who were against my position or the position that I supported and an equal number of those who were for it.

I am not complaining about having only one witness, but I am complaining that whenever we have documentary evidence or we have slides or pictures or charts, they ought to be allowed to be used. After all, that is what the purpose of these hearings is all about. And, I suggest in the future—we are going to have a number of other hearings in the future—that we work together to allow both sides to present the best case they can. That is the only way the American people can fully understand this; it is the only way that we, in Congress, can fully understand it.

I would hope that the witnesses, whether they be pro-abortion or anti-abortion, would be permitted to present whatever evidence or testimony they have within the limited time that the committee has to do this. I hope in the future we do not have these kinds of difficulties.

I do appreciate the testimony of all five members of Congress here today. I know that Senator Packwood feels very strongly, and Senator Cranston, about their positions in support of this bill. But, I also know that Senator Humphrey and Congressmen Hyde and Smith feel very strongly too. And, I think the American people feel very strongly, and they really need to get the facts of abortion—we held 12 hearings on this issue, the most extensive hearings in the history of the country, a number of years ago when I was chairman of the Constitution Subcommittee. If the people really look at the seriousness of this issue, they are not going to think it is just a choice of this or that. Americans will be concerned about the disregard for human life—and it is a disregard, and I don't care what anybody says.

I don't know what the answer is. But, I do think we need to listen to our people out there, and we need to listen to each other, and we need to try and resolve this problem in the best possible way we can. But I can tell you the answer is not in permitting more and more abortions. That, to me, is not the answer—and when the vast majority of them, 97 percent of them, are for reasons of convenience only.

We have all got to start looking at the reasons and number of abortions and not just listen to slogans. This right to choose has multiple interpretations. I hear it all the time now from the pro-abortion side of this controversy. It is time that we look at these things from a very, very careful standpoint, and we try to end the divisiveness in this country and see what we can do to resolve these problems.

With that, I am happy to have the testimony of each of our members of Congress here today, and I look forward to hearing the testimony of others as well. I do hope in the future that anybody can present whatever evidence they can, as long as the rules are the same for everybody. I would appreciate that, and frankly will insist on it in the future.

Senator METZENBAUM. Thank you very much, Senator Hatch.

Let me make clear—and I think you are aware of this—that there is only one witness on the opposite side because none others were offered. We did not deny anybody the opportunity——

Senator HATCH. I agree, but there were only a few days' notice given of the hearing, and there was not enough time to put together the witnesses that need to be put together to present both sides.

I'm not suggesting on that basis that there was any unfairness. The only unfairness I see is this business of not allowing, during the hearings, themselves, the sonographic evidence that has been brought by, frankly, one side of this issue. It is very important.

Senator METZENBAUM. Well, let me comment further on that. There was another witness on the other side of the issue who had some photographic evidence that he wanted to submit——

Senator HATCH. And, they should present that here.

Senator METZENBAUM [continuing.] And what I've said and tried to make clear is that every witness, including the members of Congress, be limited to 5-minutes. I know what the clock says. I know that there are Democratic and Republican Caucuses at noon. I know that we will be called to the Floor for votes, as we already have in one instance. I felt that any witnesses that had come from a long distance ought to be given an opportunity to be heard.

I think at the end of all the witnesses, the movie—which I understand takes 10 or 12 or 15 minutes, and which would go beyond the 5-minute limit—we will have that, and it will be included in the record as far as that part of the testimony is concerned so there can't be any question of an opportunity for it to be presented. It is just a question of when it is presented so that all witnesses will have an opportunity to be heard. We may take different positions on legislation, but that does not mean that we want to weigh in on one side or the other in the conduct of the hearing—I have not done that before——

Senator HATCH. No, and you have been fair in our past matters. I think this is more a problem between staff than it was between Senators. I just want to set the record straight. I presume, then, if Ms. Shari Richard desires to use her 5 minutes to show her sonographic evidence and testify on it, that as long as she adheres to that 5 minutes, she can do it during the hearing.

Mr. HYDE. Senator, I would yield my time, if I may, to Ms. Richard. I think her showing is so important that I am happy to yield my 5 minutes to her.

Senator HATCH. And I would have yielded mine.

Senator METZENBAUM. Congressman, I think that once we start that procedure, we would be changing our 5-minute rule because there would be some other Senator or Congressperson who would come and have that—I try to make the 5-minute rule a pretty strict one.

Senator HATCH. Why not do that? Henry Hyde is author of the Hyde Amendment; he is known all over the world for it——

Senator METZENBAUM. I know, and I have a lot of respect for him.

Senator HATCH [continuing.] And if he is willing to give up his 5-minutes, let's do it, and that solves the problem.

Senator METZENBAUM. Well, let's just go on. I want to hear from Henry Hyde, but first, if you don't mind, I think we ought to hear from Senator Coats as a member of the committee.

Senator Coats.

Senator COATS. Thank you, Mr. Chairman.

I would just add one thought to the discussion that preceded here, and that is that this is an issue of such momentous importance to the United States, a Nation which is clearly divided on this issue, seeking answers to many tough questions. I would hope that we could have extensive hearings, bringing the opinions of both sides. I think it is important for not only this committee, but important for the American people that we do that.

So whatever policies we need to enact in future hearings in order to make sure that both sides are adequately represented, I know that you want to achieve it, and I want to achieve that as well.

Senator METZENBAUM. We are willing to hear witnesses on both sides. Very seldom do we have a hearing when there are so many more on one side than the other, but that was because witnesses from the other side did not come forward. There will be additional time at a later point, I am sure.

Senator COATS. I appreciate that, Mr. Chairman.

I would like to just take a couple of minutes to make some points that I think often are not discussed. As we get involved in this very, very important debate about where this Nation is going on the subject of abortion, I think we ought to consider a couple of things that I would like to discuss.

First, it appears that new medical innovation and new social developments are changing the nature of the debate, and perhaps the ground rules, on which we view abortion. Doctors, we are discovering, are increasingly viewing the fetus as a patient. Operations are being performed on fetuses to correct irregular heart rhythms. We can now give blood transfusions to fetuses. And not too long ago, surgeons conducted brain surgery on a baby boy six times before that boy was born.

Science and law, it seems to me, are somewhat on a collision course. Legal changes and medical advances have created a situation in which an unborn child has all the rights of a patient but no legal protection. And I think this begins to strain what many of us feel is not only common sense, but common humanity.

Second, medical science is showing us that these patients are humans that respond—whether or not you describe them as humans—they are patients that respond to treatment and also respond to pain.

Professor John Noonan of the University of California Law School contends—and I quote—"beginning with the presence of sense receptors and spinal responses, there is much reason to believe that the unborn are as capable of pain as they are capable of sensation."

Now, as Americans, we have always prided ourselves on our ability to empathize with the suffering and the pain of others. We regulate the way in which animals are killed in order to reduce their pain. We regulate the way in which animals are used for medical science research in order to minimize or reduce their pain.

But in the case of abortion, no care whatsoever is taken or paid for the suffering of the aborted. And it seems that here, we are on a collision course with our very best instincts.

Third, we are facing, as all of us know, a serious drug crisis in this country. This is a crisis in which often the unborn are singled out as victims and targeted for help. Babies that develop and are born addicted to drugs are the fastest-growing group of drug victims in this country. Some suffer strokes in the womb; their skin is often so raw they cannot be touched or held by anyone; many are unable to stop kicking and moving their arms.

The question I ask is: Is it reasonable to say that these pre-born children who suffer so much are merely a part of the mother's body? Is it rational to say that a mother's decisions are hers alone? Isn't there a victim here that we ought to be thinking about protecting?

We see the cries and pleas of people across this country to reach out to drug-addicted mothers for the sake of protecting the child, to prevent the suffering and addiction of the unborn child; and yet on the other hand, we don't even pause to give thought to the suffering or the rights or the humanity of that child before it is born. And it seems to me that this is a contradiction that we need to examine and try to explain.

Now, the abortion debate I think is at a very critical turning point. Science and technology have revealed the unborn child is undeniably and uncomfortably human. It is treated as a patient like other patients; it is sensitive to pain and under a doctor's care. It can be abused and victimized like any child. And it wins our sympathies and deserves our protection; it merits our care both before and after birth. That is a fact. That is what is happening today.

Through medicine, I think we are a society coming face-to-face with a very concrete and very disturbing reality. Abortion remains an operation more frequently performed than any bedside circumcision, surpassing appendectomies, tonsillectomies, facelifts and liposuction. But technology is giving definition and clarity to America's vague, but deeply felt, unease with abortion on demand, for it is revealing the unborn child as a patient and a victim, but most of all as an individual.

This morning, I think we should not nurse any illusions about the bill before us, S. 1912. It is a vehicle for unrestricted abortion on demand. It is a method for the Federal Government to impose restrictions on States interested in protecting unborn human life.

Before some undefined moment of viability, it allows abortions for any reason whatever, including selection and birth control; after that point, it permits abortions for reasons of health, a term traditionally interpreted very broadly to mean well-being. In my view, this legislation does not serve the interest of clarifying what I think are some very disturbing questions that have to be addressed and have to be answered. And I think it abandons any pretense of carefully balancing conflicting moral claims and takes one side of an extremely complex debate.

We do need to offer caring solutions to women in crisis. We do not require the destruction of their child. And this is where I think we should devote our resources and where we should invest our compassion, and the direction that the committee ought to be taking. I hope that the testimony not only this morning, but the deliberations of the committee, the careful deliberations, listening to those on both sides, that we can begin to answer some of these seemingly irreconcilable problems that are being laid before us given the advances of medical science and given our compassion and empathy of people for all life, however it exists.

Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Senator Coats.

Senator METZENBAUM. Senator Humphrey, we are very happy to have you with us. Before you came, I had indicated that the Chair had established a 5-minute rule for members of Congress as well as for our witnesses, and I hope that won't impose upon your ability nor your eloquence.

STATEMENT OF HON. GORDON HUMPHREY, A U.S. SENATOR FROM THE STATE OF NEW HAMPSHIRE

Senator HUMPHREY. Well, first, Mr. Chairman, I arrived late on account of the vote. I would be happy to yield to my colleagues who arrived before me, as long as I get my opportunity.

Senator METZENBAUM. Go right ahead.

Senator HUMPHREY. Thank you for the opportunity to testify, Mr. Chairman.

We are here, clearly, because the U.S. Supreme Court is narrowing *Roe v. Wade*. Supporters of *Roe* want S. 1912 to take the place of *Roe* when that tragic decision is finally flung into the dark pit to molder along with *Dred Scott, Plessy* and *Lockner*.

Mr. Chairman, *Roe* was a badly flawed decision in the same way as S. 1912 is a badly flawed bill. And, to add insult to injury, it is meant to usurp all meaningful authority from the States.

Legal scholars on all sides have criticized *Roe* as unscholarly. Because this bill seeks to enact *Roe*, it likewise is unscholarly.

Here is the crux. In *Roe*, the majority dodged the central issue and claimed that they could not determine when human life begins. Here is what they said: "We need not resolve the difficult question of when life begins when those trained in the respective disciplines of medicine, philosophy and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." (*Roe v. Wade* p. 44)

Well, Mr. Chairman, that assertion is simply false; it is studied nonsense. The Justices need not have speculated at all. Mr. Chairman, if you and I were first-year medical students at Harvard Medical School, we would be taking a course in genetics—and here is the text they used in that course, *Langman's Medical Embryology*. On the very first page of the text, Mr. Chairman, here is what it has to say in answer to the Justices' dilemma:

"The development of a human being," it says—human being—"begins with fertilization . . ." (5th Edition, page 3) The very first paragraph of the first page of the text.

At Harvard, they teach that the life of a human being begins with fertilization. They use the term "a human being"—a human begin begins its development at fertilization, the text says. In teaching Harvard medical students about human genetics, they don't run from the word "human being"; they don't play word games. None of this stuff about "product of conception"; no resort to sophistry to obscure the facts of science; none of this intellectually dishonest babble about "potential human life" or the inability to determine when human life begins. They teach at Harvard that the development of each individual human being begins at fertilization.

Yet in *Roe*, the majority claimed they could not determine when human life begins. They must have been wearing blinders.

Mr. Chairman, with all due respect, I hope this committee as it considers enacting *Roe*, will not for its part wear blinders.

The Justices in 1973 did not have the advantage—they had textbooks, which they evidently ignored—but they did not have the ad-

vantages of this new medical technology called sonogram and the videotapes which are created through this new medical technology.

I hope the committee will not deprive itself of the opportunity to see this tape. It is 8 minutes. It is not sensationalist in any way. It doesn't show any blood. And I think it would be tragic and a repeat of the "blinder error", if you will, if the committee refuses, especially in light of Congressman Hyde's generous offer.

Well, they don't deny the humanity of the fetus in teaching at Harvard Medical School, because they teach science, not politics.

We can understand, especially as legislators, why the *Roe* majority chose to dodge the issue. If they had acknowledged the findings of science that human life begins at conception, then the learned Justices would have been forced to contrive a privacy right for one human being to kill another. So instead, they mumbled and invented a privacy right for one human being to kill a something-or-other, nobody knows for sure what it is. And then they rationalized further that for the purposes of human rights, human beings are not human beings until they are able to leap over some artificial arbitrary barrier such as viability.

This book is entitled, *Life: An Introduction to Biology*, and here is what it says. "The fertilized egg cell contains nuclear material from both parents, marks the beginning of the life of a new human being." The Justices must have been wearing blinders—"the beginning of a new human being".

There is simply no argument among biologists about when a human life begins. So regarding S. 1912, we have to ask the question, therefore, do we want to create a class of human beings who are disposable property. That is what the bill would do. The *Roe* majority chose precisely that, and that's the choice presented us by the bill: Do we want to create a class of human beings who can be killed at will? That is what the court did. Do we want to repeat that mistake?

If you believe in biology, *Roe* and S. 1912 are about killing human beings. Under S. 1912, abortion is unrestricted from inception until the 25th week. After that, abortion may be had if one so much as raises a claim of emotional health. In other words, it is *Roe* all over again, and of course, the proponents are very forthright about that—more killing, more millions upon millions of human deaths.

Some may take offense, I know, at my repeated and intentional use of the words, "human being", and I regret that. I regret that many refuse to acknowledge the simple scientific fact that the offspring of human beings are human beings. Sophistry can obscure that fact, but it cannot change that scientific fact. The fact, of course, is inconvenient. Sometimes it is a burden. Of course pregnancy is a burden, especially when it is not planned and in certain other circumstances such as single parenthood——

Senator METZENBAUM. Can you wind up, Senator?

Senator HUMPHREY. I will indeed.

Pregnancy is a burden—no question about that—and so is raising children, and so sometimes is caring for elderly. Life is full of burdens. I am here to plead, colleagues—I am here to plead that we not license the killing of human beings on the excuse of getting rid of burdens, because there are more humane options.

Frankly, I would not want to see a bill like S. 1912 passed in a State legislature, either. But I join with those who complain that S. 1912 is designed to preempt States from devising their own abortion policies. The abortion issue is being released from the Supreme Court where it's been locked up for 16 years far beyond the reach of State legislatures. Supporters of S. 1912 want the issue locked up again, this time by Congress, so that again it will be far beyond the reach of the State legislatures.

There is a great contradiction here. Most of those who support S. 1912, are the very same Members of Congress who complain bitterly when those of us on the other side of the issue seek to prevent the District of Columbia from spending public funds to perform abortions. They accuse us of interfering with Home Rule. Yet this bill would strip not only the District of Columbia, but every State, territory and possession of all meaningful authority to choose their own abortion policies. States that desired to restrict abortion could not.

For example, this bill would invalidate laws passed in Pennsylvania requiring informed consent, a 24-hour waiting period, spousal notification, the prohibition of abortion for sex selection and abortion after viability except to save the life of the mother. It would nullify a law passed in South Carolina which requires parental consent. It would reject a law passed in Guam that allows abortion only to save the life of the mother. It would invalidate a bill passed by the Idaho legislature which bans abortion as a means of birth control. And clearly, that's what proponents want.

Since I began speaking, 15 more abortions have been performed. There is an abortion every 20 seconds, 4,320 every day, 30,240 every week, 129,600 every month; 1,600,000 every year. Twenty-four million since 1973—each and every abortion producing a dead human being.

Some choice. It's an inhumane choice. And in nearly every case, it ought to be an unlawful choice. Killing human beings to get rid of burdens ought to be unlawful. It ought to be unthinkable to create a class of human beings who have no rights, who may be disposed of like property.

Mr. Chairman, in the political competition over this issue, hearts have hardened. We need to soften our hearts toward the unborn. We need to soften our hearts toward the youngest and smallest and weakest and most dependent and most innocent members of our family.

The contradiction is clear and striking, but that is a minor part of it. We are talking about human beings. Do we want to create a class of human beings who can be disposed of as property? That is what this bill will do.

For the sake of humanity and the love of humanity, I urge this committee to reject it.

Regarding the specter of deaths from coat hanger abortions, I cite for the record statistics from the National Center for Health Statistics, which show that the number of such deaths were declining markedly even before *Roe*. Of course, every death is a tragedy, but the argument that thousands of women died each year from septic abortions prior to *Roe* and that thousands will die if *Roe* is overturned is false.

Year and estimated number of criminal abortion deaths: 1973—25, 1972—48, 1971—75, 1970—109, 1969—115, 1968—109, 1967—135, 1966—156, 1965—197, 1964—207, 1963—234, 1962—253, 1961—271, 1960—241, 1959—235, 1958—215, 1957—209, 1956—174, 1955—211, 1954—223, 1953—230, 1952—249, 1951—226, 1950—246, 1949—298, 1948—388, 1947—457, 1946—593, 1945—694, 1944—770, 1943—910, 1942—962, 1941—1,080, and 1940—1,313.

Senator METZENBAUM. Thank you, Senator. We appreciate your statement.

Senator METZENBAUM. Congressman Hyde, you are well-known, well-respected, and as Senator Hatch said, you have a worldwide reputation. But I am going to do something for you that I did not do for Cranston nor Packwood nor Humphrey nor will I do it for Congressman Smith. I am going to allow you 6 minutes, but 1 minute of your 6 has to be devoted to telling us how you reduced your weight so much.

STATEMENT OF HON. HENRY HYDE, A MEMBER OF CONGRESS FROM THE STATE OF ILLINOIS

Mr. HYDE. Well, that's very simple. I had some surgery last July, Senator, and the doctor looked at me and how big I was, and he said, "It's not going to happen unless you lose some weight." So I was very motivated. I simply started to think about other things in life rather than the next meal, and it worked.

Senator METZENBAUM. Well, it is becoming, and I am pleased that you did. You did very well.

Mr. HYDE. The trick is to hang on now and not to backslide.

Senator METZENBAUM. We are happy to have you with us, Congressman.

Mr. HYDE. Thank you, Senator. Good morning.

It is great to be with Senator Coats and Senator Hatch and my colleagues here at the table.

I do hope you will watch the video cassette. I don't know about the Senate, but I'll tell you, in the House, we courageously go all over the globe in search of facts. We go to Australia, we go to Thailand—if there is a fact to be found, we will spare no expense nor trouble to find it. And I would hope a little of that spirit would permeate here in the Upper Chamber, and you would watch this ultrasonograph in your quest for the facts.

Let me also say, with my friend Senator Cranston, I have always admired him, and no more than in 1972 when he signed a dissent from a Presidential Commission's endorsement of abortion on request. Senator Cranston was concerned about the argument that affluent women could obtain legal abortions while poor women could not, then and as now. But Senator Cranston said he hesitated to endorse governmental sanction of the destruction of what many people consider to be human life. And then he added something which I would repeat today: "Ours has become an incredibly violent time. Has life ever been held more cheaply? Has there ever been greater indifference to the taking of life? Are we really aware of just how hardened we have become?" I say amen to that.

Now, there is no such thing as a safe abortion for the unborn. The unborn get terminated. The doctor becomes the terminator.

Actually, that's a euphemism. Every pregnancy terminates at the end of 9 months. This is exterminate—the exterminator. So the mortality rate on abortion for the unborn is 100 percent.

I notice in your bill and in the House bill the unsavory word of "abortion" is never used, even though that's what we are talking about here. That is the issue—the killing of unborn children. But the bill somehow recognizes the unsavory connotation of the word "abortion". I don't see doctors hanging a shingle out, saying "Abortionist". There is still something a little distasteful with that word. And so we talk about "terminate a pregnancy", "reproductive rights". Under this bill, there is going to be a lot of nonreproduction, as far as I can see. But nevertheless this pays tribute to the fact that abortion still rubs people the wrong way.

Now, I take my text from our country's birth certificate—the Declaration of Independence—and nobody said it better: "We hold these truths to be self-evident"—they are even beneath discussion—"that all men are created equal"—"created", not "born", "created"—and by "men", it means mankind, members of the human family—"and are endowed by their Creator"—it is not an achievement, it is not something you get at 6 months or 6 years; you are endowed with it because of your membership in the human race by the Creator; that is the source of our human rights, our dignity, why we are different from a mule, why we are different from a chicken. We are endowed by our Creator with inalienable rights—not even this committee can take away the right to life because that's the first right, guaranteed and given to us in our country's birth certificate. That, it seems to me, is the American way—not killing unborn children.

Now, "freedom of choice"—what a ring that has. That resonates. Pluralism. This is America. The right to choose. But nobody has the right to choose when the choice involves the destruction of somebody else's rights. If a husband beats up his wife, wouldn't you say the government ought to intervene in that? Does the husband have the right to beat up his wife? Does a father have the right to beat up his children and abuse them and brutalize them? Wouldn't you say it is proper for the government to intervene there? Of course you would.

Does a pregnant woman have the right to choose to use crack while she is pregnant? You would say no, I would assume. So there are some circumscriptions of these rights, with reference to a woman's right to choose. To choose to kill your child, it seems to me, is no right at all. It is clinically primitive to deny the humanity of the unborn. The unborn is not a chicken or an abscessed tooth or a diseased appendix. It is a member of the human family.

Now, I think it is a given under the statistics that have been taken and the polls that have been taken that the public divides into 20 percent who don't want abortions for any reason, 20 percent who say abortion should be unrestricted, which is what this bill says, really, and then the middle 60 percent who want some restrictions on abortions—some reason, some cause, recognizing that there are moral implications to exterminating an innocently inconvenient young child.

This bill says abortions with no exceptions whatsoever. In fact, Don Edwards, its House sponsor, says that's it, no exceptions. It provides no exceptions whatsoever.

Now, that rides roughshod over 80 percent of the public, it seems to me; the 60 that want parental consent or spousal consent or informed consent, who don't want abortion used as retroactive birth control or as a means of gender selection or as a means of enforcing a population policy. You are going to hear about Romania. Don't forget China, where they coerce abortion. So there are two sides of that street.

One more second, if I may, Mr. Chairman.

Senator METZENBAUM. Certainly.

Mr. HYDE. Fetal viability is undefined; abortion is permitted at any time because health is defined as including one's emotions; and last, believe me, this is a civil rights issue.

Whom do we include within the circle of those society will be responsible for—the handicapped, the aged, the terminally ill, the incorrigibly poor—yes—but what about the unborn? Are they nothing? This bill makes them nothing.

Thank you for indulging.

Senator METZENBAUM. Thank you very much, Congressman Hyde.

Congressman Smith, we are very happy to have you with us.

STATEMENT OF HON. CHRIS SMITH, A MEMBER OF CONGRESS FROM THE STATE OF NEW JERSEY

Mr. SMITH. Thank you very much, Mr. Chairman and members of the committee.

Mr. Chairman, I believe the time is fast approaching when historians will look back at America's unseemly and very tragic abortion culture of today with a mix of incredulity and sorry. They will wonder how a society that paid so much attention to civil rights at home and human rights abroad could have allowed and even promoted the violent destruction of over 25 million children. They will weigh the profoundly misleading cliches, slogans, euphemisms of our day proffered by the abortion lobby against the brutal reality of abortion—literal dismemberment of the baby and poison shots—and wonder how, in an ostensibly sane, compassionate society, could have been so deceived.

All of this I think will be viewed particularly perplexing in light of the tremendous advances made during the Seventies and Eighties in society's understanding of human life before the event of birth. Senator Humphrey, Senator Coats, Congressman Hyde spoke so eloquently on this point just a moment ago, and in any discussion of this issue, I think all should be intellectually honest enough to acknowledge that birth is an event that happened to each and every one of us; it is not the beginning of a child's existence.

While is true that the abortion is cloak the deed, Mr. Chairman, in the language of humanitarianism and basic rights, the fact of the matter is that abortion is child abuse. Children who suffer this abuse, as I said, are cut, they are dismembered, and millions have been killed by injections of poison.

Mr. Chairman, this is not an issue of choice. It is not an issue of who decides. This is an issue of child abuse, and it is not a matter of choice in a civilized society.

Mr. Chairman, in a common method of abortion, known as suction or vacuum aspiration, a loop-shaped knife attached to a high-powered suction machine literally rips and shreds the unsuspecting child to pieces. In a D&C and D&E abortion, the child is dismembered—literally dismembered—by a surgeon's scalpel without even the benefit of anesthesia.

In saline abortions, Mr. Chairman, usually done in the second trimester, the unborn child has his or her life purposely snuffed out by an overdose of injected salt water. A baby terminated in this way dies a very slow, excruciatingly painful death. After the salt is injected by a hypodermic needle, the child breathes in the fluid and gets sick. The salt burns the outer layer of the skin and gets into the bloodstream and kills the vital organs of the child. A day or two later, the mother goes into labor and gives birth to a dead, chemically burned baby.

Mr. Chairman, this is the horrific reality of abortion—dead babies—and as we all know, every abortion stops a beating heart.

Mr. Chairman, at a time when serious reevaluation of abortion on demand in this Nation is underway in many of our States, S. 1912 and its companion measure in the House seeks to rob the States of their ability to protect life and to restrict abortion.

Mr. Chairman, this legislation is extreme, it is unwarranted, and it discriminates against children. It reduces unborn babies to the status of property and regards them as objects.

Mr. Chairman, let me note here also that I am very deeply disappointed that the abortion lobby is trying to confuse the public by drawing parallels between efforts to protect human life in America to the deplorable policies of Romanian dictator Nikolai Ceaucescu. Mr. Chairman, as member of the Helsinki Commission and the House Foreign Affairs Committee and the Human Rights Committee, I along with Frank Wolf of Virginia and Tony Hall led the fight to end U.S. support for the Ceaucescu regime. I was the prime sponsor of the legislation to suspend Most Favored Nation status to Romania because of human rights abuses in that country which was adopted after a bitter 3-year fight.

Mr. Chairman, Ceaucescu, like the population control policies in the People's Republic of China, used draconian measures in this case to force women to have big families. Romania, like China, imposed quotas. They were wrong. In China, the communists rigidly enforced their one-child-per-couple policy or quota with forced abortion and involuntary sterilization. In Romania, the government's quota was at least five children per family, and Ceaucescu cared nothing for human life or human rights, imposed harsh penalties on those who didn't produce children for the State. That policy, Mr. Chairman, like China's is inhumane; it is indefensible.

Mr. Chairman, as you probably know, the National Salvation Front, the interim government, has wisely ended the child quota system. I was in Romania, as I have been on many occasions, on another human rights mission just a couple of weeks ago, and I saw substantial evidence that like here in the U.S., the issue will

indeed be debated and focused upon, perhaps as early as after the May 20th election of a new government.

Nowhere here or in Romania, however, and no one, suggests a return of the Ceaucescu-like government child quotas. But that doesn't say that the unborn don't deserve protection.

Mr. Chairman, as in Poland, where human rights leader Lech Walesa and many in Solidarity have begun pushing to enact meaningful protection for the unborn, Romania, as it sheds its dictatorship, will likewise revisit this issue and hopefully over time will evolve a protection or protections for the unborn.

Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Congressman Smith.

I note that one of the members of this committee who had a previous engagement and could not get here until this moment is with us now, and I am very happy to recognize Senator Adams, one of the most respected members of this body.

Do you have a statement, Senator Adams?

Senator ADAMS. I do, and thank you very much, Senator Metzenbaum. I am chairing another meeting of a subcommittee of this committee, but I have specially recessed that so I might come and make a statement. Therefore, I apologize for interrupting, but on the other hand, I want very much to make this statement.

OPENING STATEMENT OF SENATOR ADAMS

Mr. Chairman, I had hoped that by 1990, we would be past the debate in this country regarding the protection of the right of women to choose. Apparently, we are not.

Last week we saw legislatures in Idaho and Guam pass laws which, if allowed to stand, will severely and tragically restrict a woman's right to make decisions regarding her own body.

In 1973, after nearly 20 years, the U.S. Supreme Court held in *Roe v. Wade* that the Constitution protected a woman's decision regarding whether to terminate a pregnancy. It is unfortunate that the court has now forced us to act to protect American women. The court sent a message to women in the *Webster* decision, and it was a simple one: Don't count on us to protect your right to make the most private decision of your whole life without interference or regulation from the government.

Mr. Chairman, it is now up to us in Congress, the Congress of the United States, to protect the woman's right to choose. Be assured the women of America will hold us accountable, and they should.

Senate bill 1912 codifies the *Roe v. Wade* decision and addresses the fundamental question of this debate: Who decides? Do individual women, facing what must be and will be the most emotionally wrenching decision of their lives, make that choice? Or will it be made by the State—by the State, by a faceless bureaucrat?

The protection of individual liberties has been our guiding principle for over 200 years. It has been the guiding principle in our Nation since its inception. Many of our colleagues are proud of their records defending individuals from interference by the government. I can think of few issues which demand as little attention

in our government as this one; the government should not be regulating here.

I do not ask anyone to favor abortion. I simply ask that we allow individual women to turn to their own conscience—their families, their clergy, or whomever they decide or choose to confide in—to make a difficult personal decision without the interference of the Federal Government or any State government.

Mr. Chairman, I can think of few issues we face as important as this one. We cannot go back to the pre-*Roe* days of butchers, back alley abortions, and unwanted pregnancies. We moved past that in 1973 with the *Roe v. Wade* decision. We must now move forward to another pressing agenda—how to feed, house, clothe and educate all of the children of America, rich and poor alike, who are here and who so desperately need our attention.

It was recently said that President Bush follows public opinion polls closely before determining public policy. Well, I hope the President is listening to the American people on this issue. The majority of American people want to preserve—and I stress preserve—the right of an individual woman to make her own choice.

S. 1912 is not a pro-abortion bill, and it is not an anti-abortion bill. It is a bill that preserves that most fundamental freedom on which our Nation was founded—the freedom to believe as one likes, to have privacy over one's person, and to exercise those fundamental rights without government interference.

Thank you very much, Mr. Chairman, for giving me the opportunity to state my beliefs in this matter.

Senator METZENBAUM. Thank you very much, Senator Adams. We are very happy to have you with us, and if you have to leave to go back to your other hearing, I certainly understand that.

Senator ADAMS. Thank you, Mr. Chairman.

Senator METZENBAUM. The chair is anxious to move forward to hear all of the witnesses, but does not want to preclude any member of the committee from asking such questions as he may have. I would hope they would be rather brief.

I understand, Senator Hatch, you have some questions.

Senator HATCH. Just a couple.

Let me ask Senator Cranston, Senator, in the bill you provide that abortions may be performed—Section 2(a)—they may be performed if a physician determines that the fetus is not viable.

Now, could you give us your definition of what constitutes viability? [Pause.]

Senator CRANSTON. The point is that it was determined in *Roe v. Wade* that this is a medical decision that should be made in consultation with a doctor. I don't profess to define what viability is, but under *Roe v. Wade*, that would be determined by a physician in consultation with the woman.

Senator HATCH. OK. Let me just ask you this question. What occurs if the abortion is performed, and the fetus is viable? Do you propose that it should gain the protections under the Baby Doe statute, which you and I carefully crafted in the past? As you will recall, this legislation prohibits the denial of medical care to newborn infants except under very narrow circumstances. So would that baby be protected by the Baby Doe statute?

Senator CRANSTON. The U.S. Supreme Court has required that the physician can be required to be present to make that determination.

Senator HATCH. So you leave everything right up to whatever physician it may be?

Senator CRANSTON. Yes.

Senator HATCH. And, if the physician believes solely in pro-abortion policies, that physician can do whatever that physician wants to do.

Senator CRANSTON. If the physician makes the determination that the fetus is viable, then action should be taken accordingly.

Senator HATCH. OK. Let me just ask a couple questions of you, Representative Hyde. As I read this bill, it is so broadly drafted that it virtually allows for unrestricted abortion on demand under all circumstances. Do you agree with that?

Mr. HYDE. Yes, sir.

Senator HATCH. I don't see how anybody can argue against it.

Mr. HYDE. You are going to have the abortionist making the determination as to viability. As Senator Cranston has explained it, the doctor makes that judgment, I guess, and he may well have a conflict of interest; I don't know.

Senator HATCH. So it allows unrestricted abortion on demand for all 9 months of pregnancy.

Mr. HYDE. Yes, sir, because it says after viability, you still can get an abortion if the woman's health is endangered. But "health" is defined very broadly, and it includes age, emotional State, and subjective factors like that. So if a woman wants an abortion, and she is 9 months' pregnant, and she is emotionally distressed at having to carry this child because maybe she has had a fight with her husband and does not want his child, under this bill she could get an abortion.

Senator HATCH. I see. Is it also true that this legislation does not address parental consent or any notification requirements whatsoever?

Mr. HYDE. It is without any restrictions. Those are the exact words of the chief House sponsor, and I rather think they apply over here. There are no restrictions on abortion.

Senator HATCH. And, there are no requirements at all to notify the parents in the case of a minor?

Mr. HYDE. No parental notification, no spousal notification, no informed consent, gender selection—if you want a boy, and she is carrying a girl, you can exterminate the unborn.

Senator HATCH. Is there any provision in this bill that prohibits abortion if the pregnant woman or the father dislike the gender of the child?

Mr. HYDE. None whatsoever. That would be grounds for an abortion under this bill—or no grounds, no exceptions.

Senator HATCH. In other words, this bill actually amounts to a sex-selection bill.

Mr. HYDE. You can use it as retroactive contraception.

Senator HATCH. Well, as I understand it, the Baby Doe statute that Senator Cranston and I crafted, which answered some very serious problems at one time, requires medical care if a baby is viable, and care may only be denied under the Baby Doe statute if

the saving of the infant or if further care to the infant is really futile to keep the infant alive. You are aware of that?

Mr. HYDE. I am aware of that.

Senator HATCH. OK. Under that statute, there is basically no physician discretion unless the care would be futile; is that correct?

Mr. HYDE. I understand that, yes.

Senator HATCH. So it isn't a matter of whether the physician finds viability or not; once that baby can live, then under Baby Doe, current law, you cannot allow that baby to die if that baby can be medically saved.

Mr. HYDE. If the law is enforced in the abortion clinic, yes.

Senator HUMPHREY. Senator Hatch, may I offer a suggestion?

Senator HATCH. Yes.

Senator HUMPHREY. Relative to the kinds of restrictions you have cited—sex selection, parental notification, informed consent, that sort of thing—I think you have an excellent opportunity to ask the principal proponents of the bill right now to establish the legislative intent in case the language, which some argue is very, very broad indeed, in case there is any uncertainty at all about the legislative intent, it ought to be established right now.

Senator HATCH. Well, I don't think there is any doubt of the legislative intent. It is to allow abortion on demand, period, regardless of the fact that 60 percent of the people are very disturbed by the widespread abortions in this country even though a number of those people would like to provide a right of choice.

Let me just ask——

Senator CRANSTON. Senator Hatch, could I comment?

Senator HATCH. Yes.

Senator CRANSTON. The bill does not authorize abortion on demand at any stage of pregnancy. The bill codifies the *Roe v. Wade* decision, which allows a State to prohibit abortion from the third trimester except where termination of a pregnancy is necessary to protect the health or life of the woman.

On the issue of whether even very late in the pregnancy, an abortion might be authorized because of a mental health problem, the court has held that a woman and her physician could determine that an abortion was necessary after viability on the basis of mental or physical health. But there is no evidence that women are going to fabricate reasons to have a third trimester abortion. It has not happened under *Roe* in 17 years.

According to statistics published by the Alan Gutmacher Institute, 91 percent of the abortions in this country take place in the first trimester, with about .01 percent, roughly 100 abortions, after the 24th week of pregnancy. But in fact, the number of third trimester abortions reported may be quite high and inaccurately high, since one study found that 78 reported abortions past 24 weeks were classified incorrectly and actually occurred at an earlier point.

Additionally, two of the remaining three involved a gross fetal deformity where the fetus lacks brain development and is certain to die within hours of birth.

Mr. HYDE. Senator.

Senator HATCH. Let me just say this. I have to tell you there is no such standard in this bill.

Do you have any comment, Congressman Hyde?

Mr. HYDE. Well, just the words of the bill say that at any time, if such termination is necessary to protect the life or health—now, they define "health" under *Doe v. Bolton*, which includes emotional distress. So if a woman is carrying her child, and she is well along, and she wants an abortion for whatever reason—she is emotionally distressed by carrying this child—under this bill, she could get an abortion.

Senator PACKWOOD. Mr. Chairman, as one of the authors of this bill, can I come in on this? I am willing to make Senator Hatch an offer, which I hope he will not refuse. We wanted to craft this to make the law as it was under *Roe*; we didn't want to change it. We didn't want to get into the *Grove City* argument, are we changing a law.

So if you are willing, I am willing to sit down with you and attempt, if you want to recraft this bill, so long as in good faith you are willing to say what you will be willing to do is to make this statute statutorily read like *Roe* reads constitutionally.

Senator HATCH. Well, as you know, *Roe v. Wade* has led to abortion on demand; I don't think there is any question of that.

Senator PACKWOOD. No, it hasn't led to abortion on demand.

Senator HATCH. It certainly has.

Senator PACKWOOD. Orrin, you're out of your mind. It doesn't allow abortion on demand.

Senator HATCH. It takes one to know one, Bob, is all I can say. [Laughter.]

Senator HATCH. Medical technology, of course, has changed since 1973. There is no question that we can save babies now at 24 weeks, and we are doing it all over the country and in our own Primary Children's Hospital in Salt Lake City, I think the most up-to-date medical center for children in the world.

Senator PACKWOOD. Well, then you've got viability at 20 weeks.

Senator HATCH. Unless it is an abortionist doctor, I guess. How do you answer that?

Senator PACKWOOD. Well, then, of course, what you are saying is now we're going to go to doctors who will simply lie, and——

Senator HATCH. I think many would say could happen.

What do you have to say about that, Congressman Hyde?

Mr. HYDE. Well, I am not here to disparage the medical profession or the legal profession, except that we do prosecute a few doctors every year——

Senator HATCH. We've got liars in both, I might add.

Mr. HYDE [continuing.] For malpractice and for abusing Medicare. But if a woman comes in to see a doctor, and she wants an abortion, there must be a reason she wants the abortion. She must be distressed with her pregnancy. And I have not heard a definition of "health" any more stringent than that under *Doe v. Bolton*, the companion case to *Roe v. Wade*, which includes everything including the kitchen sink—emotional distress. So all she has to tell the doctor is, "I am emotionally distressed, I am upset at this," and she qualifies. The doctor doesn't have to lie, but if the woman wants her abortion, she gets one by telling the doctor this subjective condition of hers; she is distressed.

Senator HATCH. Where do most of these women go? Do they go to a regular hospital or a regular obstetrician-gynecologist?

Mr. HYDE. Well, there are clinics that are set up to——

Senator HATCH. What kind of clinics?

Mr. HYDE. Pardon?

Senator HATCH. What kind of clinics?

Mr. HYDE. Abortion clinics.

Senator HATCH. Well, doesn't that play a role here?

Mr. HYDE. They don't say that, though; it is "reproductive rights center" or something.

Senator HATCH. I see. OK——

Senator METZENBAUM. I'd point out to my colleague, the ranking member, that it is 11:00. I've got a number of witnesses. You won't stay late when they all want to be heard. I want to hear them. You are going to complain if I don't have time for the movie. I am just going to have to move ahead at this point.

Senator HATCH. That will be fine. I think basically we got to some of the debate issues.

Senator PACKWOOD. Could I—I think I may have forgotten to ask to have my entire statement in the record because I abbreviated. Could I do that?

Senator METZENBAUM. All of the statements will be included in the record. I think I already previously ordered that.

[The prepared statement of Senator Packwood follows:]

PREPARED STATEMENT OF SENATOR PACKWOOD

Mr. Chairman, I am pleased to appear before the committee as an original sponsor of S. 1912, the Freedom of Choice Act. I would like to begin with a quote from a statement I made on the Floor of the United States Senate:

"I am submitting this national abortion law today because the present laws are such a hodge-podge that the current situation in this country is chaotic, inconsistent, discriminatory and full of injustice."

Mr. Chairman, I did not make that statement in 1989 when we introduced the Freedom of Choice Act. I made that statement on May 3, 1971, when I introduced the "National Abortion Act." Which would . . . in spite of the lapse of nearly 20 years, I would be hard-pressed to come up with a more appropriate description of the present situation.

The theme of today's hearing on the Freedom of Choice Act is "Life before *Roe*." I can tell you a great deal about life before *Roe*, because my interest and participation in this issue predates this decision. At that time, in a majority of States, abortion was permissible only to save the life of the woman. At the opposite end of the spectrum were States like Alaska, Hawaii, Washington and New York, which made the decision about whether to have an abortion a matter between physician and patient.

The effect of these differences between States was that middle and upper class women could obtain a safe and legal abortion, if they could travel to one of those four States or to a foreign country, where abortion laws were more liberal. A woman mired in poverty and facing an unintended pregnancy was almost certainly forced to bear a child or obtain an illegal abortion, often under dangerous circumstances.

My home State of Oregon was no exception. Until 1969, abortion was illegal except to save the life of the woman. In 1969, the law was expanded to legalize abortion where the health of the woman was jeopardized. However, abortions had to be performed in hospitals, which made them very expensive.

As in all States, some doctors in Oregon performed illegal abortions. One such doctor was Dr. Ruth Barnett of Portland. *The Oregonian* reported that about 75 percent of Dr. Barnett's patients were referred by other physicians, including some leading gynecologists and obstetricians. In the many years of her practice, her clinic was raided several times and she was arrested repeatedly. At the age of 74 and suffering from cancer, she was sentenced to serve 15 years in the Oregon Penitentiary.

I'm sure many people would condemn Dr. Barnett for performing illegal abortions. However, she did it in part of fulfill what she saw to be the very real need of women for access to safe abortions. Upon her release from the penitentiary after serving part of her sentence, Dr. Barnett wrote a book called *They Weep on My Doorstep*. This book is an excellent history of the dilemma faced by the medical profession before *Roe*. Mr. Chairman, I would like to request that a copy of *They Weep on My Doorstep* be printed in the record.

The National Abortion Act, which I introduced in both 1970 and 1971, made very little headway in Congress. I could not get a single cosponsor, let alone hearings. Then the *Roe* case was decided, and the entire landscape changed. Abortion became legal in every State, as a matter of constitutional right. Finally women facing unintended pregnancies were given the right to choose.

As we now know, the protection guaranteed by *Roe* turned out to be only a hiatus. Court decisions and actions of Congress, such as the Hyde amendment, have gradually chipped away at aspects of the right to abortion, until finally last year the Supreme Court opened the floodgates to so-called State "regulation" with the *Webster* case. We have seen every kind of attempt to outlaw abortion since *Webster*, all in the guise of "State regulation." Last week the governor of Guam signed into law the most restrictive legislation we have seen since before *Roe*, outlaying abortion in virtually all cases. The Idaho legislature has enacted a similar law. In my home State of Oregon, initiatives may be on the November ballot which would outlaw abortion in most cases, define some contraceptives as abortion, and attempt to define when human life begins.

These types of proposals are probably unconstitutional, but it will take time for courts to determine this. Meanwhile, many women will be subject to these laws, and many more could be affected by the myriad of anti-abortion legislation and ballot measures, which are waiting in the wings in the majority of other States.

In essence, we are very nearly back where we were before *Roe*. The need for Federal legislation is the same as it was at that time. We need a uniform law that guarantees to every woman the constitutional right to choose abortion no matter where she resides. The reasons for passing such legislation are the same as those I detailed in the Senate in 1971:

1. It will allow abortion to be dealt with according to safe medical procedures, virtually eliminating deaths and injuries from abortion.

2. A Federal law would be evenhanded, fair and nondiscriminatory, giving the same rights to every woman, regardless of economic circumstance, wherever she may live.

3. A Federal law would leave the moral, ethical and religious issues to the individual conscience.

4. A Federal law would leave doctors free to practice medicine, and leave undisturbed the critical doctor-patient relationship.

5. Keeping abortion legal and available would help to ensure that most abortions continue to be done at an early stage of pregnancy, when there is least medical risk to the woman and less controversy and concern about fetal viability.

Mr. Chairman, in closing I request that those portions of the *Congressional Record* from April 23, 1970 and May 3, 1971 which deal with the National Abortion Act be made a part of the record of this hearing. Thank you.

Senator HATCH. If I could just add one last comment. You know, I have worked very closely with Senator Cranston through the years, and we have worked very closely to create a civil rights bill for newborns because we were concerned about certain physicians' lack of care. And, the Baby Doe statute that we did craft was for some of those concerns.

What I am saying is that this issue is not quite as simple as it seems. And, regardless of which side you are on in this matter, we have to look at this pretty thoroughly.

I'm not for a codification of *Roe v. Wade*, because I think it has led to precisely what Representative Henry Hyde has said it has led to. And, I apologize for not asking questions of all of you, but because of time, I have limited the questions

Senator METZENBAUM. With that, we want to thank the Congressional representatives for their participation. You were very help-

ful. We look forward to working with you as this matter proceeds through the Congress.

Our first panel includes Sheri Matulus of Peoria, IL; Marilyn Mosley of Birmingham, AL; and James Friedl, of Concord, CA.

The chair will repeat that which I think the witnesses already know, and that is there is a 5-minute limit for each witness.

Ms. Matulus, we are very happy to hear from you.

STATEMENTS OF SHERI MATULUS, PEORIA, IL; MARILYN MOSLEY, BIRMINGHAM, AL, AND JAMES FRIEDL, CONCORD, CA

Ms. MATULUS. Thank you, Senator.

I think I should begin by mentioning that although I have been called a "murderer" and a "baby killer" all too frequently in the past, and it would seem that perhaps that is still the attitude on the part of some who have spoken here this morning, I think that I should make it clear that I am in fact a woman who dearly loves her five children, her three grandchildren and her husband of 42 years, any of whom I would gladly lay down my life for if need dictated.

What I also am, in fact, is a victim—the victim of a rapist, an illegal abortionist, and a misogynist society. And it is this aspect of my life that I have come here to tell you about today.

Back in the mid-1950s, I was very viciously, sadistically raped while coming home from work late one night. I know time is limited here so I won't go into detail about the assault itself, except to say that the assailant knocked me down and out, raped me, and then for good measure he slit my abdomen open, to the extent that I literally had to hold myself together to get the rest of the way home. Fortunately, it wasn't very far. If it had been, I am sure I wouldn't have survived. And, about a month later, when I discovered I had been impregnated by the rape, I found myself almost wishing I hadn't.

To make a long story as brief as possible, I went to see two legitimate licensed physicians, neither of whom could offer anything more than some totally unacceptable advice—namely, that I carry to term and then put the infant up for adoption.

This advice did not take into consideration, gentlemen, that I already had two children; that I would later go on to have three more; and that I could scarcely say to my mother-in-law or to the rest of the watching world, "Well, gee, we just really didn't like the third kid's looks, so we gave him away." Nor did it take into account that I considered what had been forcibly and violently implanted within my body to be almost—not quite, but almost—as repulsive as the prevailing idea at that time that I was nothing more than in incubator or a petri dish or a brood mare, put here to service the whims of others.

I am a person in my own right now, today, and I was a person in my own right then. And because I was, and because I could find no doctor to afford me the medical procedure I needed, and when none of my many attempts to self-abort worked, I was obliged to go see the local back alley butcher—a man who, unlike the doctors I had seen, had no reason to fear the police because he was paying them

off. It was in fact a policeman who put me in touch with him and who told me where to go.

And when I got there, when I entered this dark, dirty old building with my hands shaking and my heart in my throat, when I walked up those three flights of pitchy stairs and got to the door at the top of them, it cost me $1,000 to get through that door—$1,000 made up of pennies and nickels and dimes saved up over a very long period of time, money that I had attempted to scrape together to put away for a down payment on a home for my family—and every bit of it gone to pay for a dirty knife.

This was in 1954, gentlemen, a time when a dollar was worth probably three to four times what it is today, and I was about two and a half months into the pregnancy. Today an abortion at that stage, done safely, would cost about $250. But in 1954, I had to hand this drunken old butcher four times that amount, and it bought me the most painful and degrading experience of my life.

After I had been given two aspirin, which was the anesthetic, I was led down a hall to a filthy little room with cobwebs hanging from the ceiling and a slop bucket placed at the end of what resembled a dirty old kitchen table. The abortionist was pouring himself a drink of whiskey as I went into the room, and the first thing he said to me was: "You can take your pants down now, but you should have—ha, ha—left them on before."

Then he told me to lie down on the table. And when I did, what I saw coming toward me was a man with a whiskey glass in one hand and a sharp instrument in the other and both hands shaking.

After he had downed his drink, he doubled his fist over my face, held it about two inches from my face and said: "This is going to hurt—and you'd better keep your mouth shut or I'll shut it for you."

I didn't doubt him at all, not for a minute, and I did keep my mouth shut—through about 15 minutes of the most eyeball-popping pain you could ever imagine.

And then, when the whole gruesome procedure was finally over, I guess he felt I hadn't been hurt or humiliated enough, because he proceeded to offer me $20 of my $1,000 back if I would perform a devious sex act.

This, and the hemorrhaging and the peritonitis and the hospitalization that followed, was what I had to go through to terminate an unbearable pregnancy. And I consider that I was twice raped, gentlemen—once by the fiend who disemboweled me, and again by a blue-nosed and hypocritical society that, however inadvertently, gave a drunken old butcher license to practice while withholding that license from reputable physicians.

I am here today because as a mother who does love her children and her grandchildren, I don't even want to think about any of them having to endure the pain and degradation that all too many women suffered prior to 1973. I can take being called a "baby killer"; I have taken it for years. What I can't take is being part of a society that willfully degrades and tortures its female members. That shameful part of our history should be buried once and for all with its victims.

I thank you for hearing what I have had to say.

Senator METZENBAUM. Thank you very much. That is as powerful a testimony in support of this bill as any I have ever heard. You are a very brave women to come before us and share your experience with us.

Ms. MATULUS. Bravery came in about 35 years ago.

Senator HATCH. I agree with that, Senator Metzenbaum. Ms. Matulus testified before the Constitution Subcommittee back in 1982, and I remember your testimony then. And I have to say the President has indicated that he will certainly resolve the problem that you had to go through. So my heart goes out to you. I think you have lived with this all these years; it has been a terrible thing, and you should not have had to go through that. It is that simple.

Senator METZENBAUM. Ms. Matulus, I think your testimony provides strong and convincing reason, and emotional reason as well, why we can't go back to that period that existed prior to *Roe v. Wade*.

There are many people like you who remember what it was before the U.S. Supreme Court decision, and they were driven to do desperate, shameful things in order to end unwanted pernancies. Unfortunately, I think some want to ignore that history and pretend that women did not die from botched abortions.

It is easy for us in the Congress to make great speeches about this issue. It is not easy for women such as you, who have lived through the experience of rape and then an abortion at the hands of a butcher. It has happened to too many women.

Now, it is clear from your testimony that women are willing to risk everything, even death, to end unwanted pregnancies.

Let us assume for the moment that we passed legislation that totally prohibited abortions for any reason whatsoever. In your mind, do you believe that it would stop abortions in this country by making them illegal, or would we only be driving women into the back alleys, the barbershops, and the three flights of stairs in order to find a darkened room with a butcher with a knife in his hand?

Ms. MATULUS. Of course, I think we all know that it would not stop abortions. There were, from figures that I have, almost as many abortions occurring prior to 1973 as there were afterwards, the primary difference being that a woman now can have a safe abortion, whereas before she was under the same type of circumstances I had or worse. There were many circumstances that were worse than mine—women who were led into garages blindfolded, where mechanics worked on them after they had worked on cars, without even washing their hands. Most of these women did end up in hospital wards, and a lot of them died.

And if I may, sir, earlier there was some mention about the Declaration of Independence; I believe Congressman Hyde mentioned that. I love my children, my husband and my Constitution. And the Constitution is the law of this land, and the Constitution, I would remind everyone, refers to "all persons born" when it talks about citizens.

Senator METZENBAUM. What is your greatest fear if the U.S. Supreme Court were to overturn *Roe v. Wade*, and States once again denied safe access to legal abortions?

Ms. MATULUS. My greatest personal or subjective fear, of course, would be for my own children and for their children. These are the people that I am closest to in the world.

My greatest objective fear would be for 53 percent of our populace, for all women, because I think safe, legal abortion is necessary for all women.

Senator METZENBAUM. Tell me, how old are your children?

Ms. MATULUS. My oldest is my daughter, who is 39, going to be 39; my youngest is a young man who is 26.

Senator METZENBAUM. And do any of them take issue with their mother speaking out on this subject?

Ms. MATULUS. Not at all, sir.

Senator METZENBAUM. Thank you. They should be very proud.

Our next witness is Marilyn Mosley, from Birmingham, AL.

Ms. Mosley, we are very happy to have you with us.

Ms. MOSLEY. Thank you very much, Senator.

I come to speak today on the issue of choice. I come to tell my own personal story. I am a 52 year-old grandmother. I have four children. I have four grandchildren, two of whom are female.

I come to talk about a young woman of the age of 20 years old who found herself pregnant, with one child who I had borne at the age of 18.

I want to tell you how I self-aborted myself. Everyone here today has talked about the back alley abortionist, and everyone here has talked about doctors and doctors lying and women lying. But the fact of the matter is that once a woman has made a choice to abort, that is really a firm choice. It is not a choice that is made willy-nilly. It is a choice that a woman thinks about and then decides that this is the only thing that she can do.

At the age of 20 years old, I was living in White Plains, NY. I was working as a domestic. And as I said, I found myself pregnant.

I really and truly at that time became a little crazy. I could not think of how I was going to terminate this pregnancy. I did all kinds of things to self-abort, from taking quinine and turpentine, to taking black draft, to taking epsom salts, to taking all kinds of laxatives, to taking hot baths where I literally cooked myself, to eventually coming to the conclusion that the only thing that I could do was to do what other friends had done, which was to resort to knitting needles.

I bought a pair of knitting needles in F.W. Woolworth's in White Plains, NY. I did not buy the little fat kind; I bought the long, thin kind. I then proceeded to buy a flashlight and a mirror. The flashlight was so that I could see exactly what I was doing and so that I would have a mirror so I would be able to look.

I had a pail, I had a flashlight, I had a mirror, and for two consecutive days, I tried to induce a period that was a month late.

It is a horrendous experience to try to self-abort. It is something that most women have done if they have found themselves pregnant and have no money, and that was what I did.

I was eventually successful, and I did self-abort.

I would like to say that after the procedure, I hemorrhaged; I did not go to the hospital because of fear. I would also like to say that if *Roe v. Wade* is overturned, abortions in the United States will

not stop. Women will go back to aborting themselves or they will go back to back alley abortionists.

I do not want that for my grand-daughters, of whom I have two. I fight for their right to carry a pregnancy to term. I will fight for their right to terminate a pregnancy. I do not think that anyone can make me carry a pregnancy to term if I was of childbearing age. I think that that is my choice. I think that that is a right that I have.

If I as a young woman of 20 decided in 1958 to terminate a pregnancy because I knew that other friends had, and I knew that there was a way that it could be done, and I had no money, then if I were a young woman today, and abortions were illegal, I would do the same thing again, because I believe that having a choice to terminate a pregnancy is a personal right, and no one can take that away from me—no one.

Thank you very much.

Senator METZENBAUM. Ms. Mosley, that is two witnesses we have heard who are so powerful, and I am only sorry that some of the legislative opponents of this legislation were not here to hear your testimony.

Do you live in Birmingham now?

Ms. MOSLEY. Yes, I do, Senator.

Senator METZENBAUM. And do you work?

Ms. MOSLEY. Yes, I do, Senator. I work part-time.

Senator METZENBAUM. And when you decided to abort, you talked about long needles, thick needles, an area that is completely foreign to me. How did you know what to do? To whom did you look for assistance? Was there anyplace you could go?

Ms. MOSLEY. No. In 1958 abortions were illegal, and there was no place to go; there was no one to look for, no one to look to. The only people you talked to—you talked to friends, and you talked in whispers.

When people who have never been in my shoes, when people who have never missed a period, who may think that they are pregnant but who wait and wait, and the period does not come, you then decide, after thinking about it, what am I going to do. And if you have no funds, if you have no dollars, then the choice is quite clear what you will do if you have decided you are not going to carry the pregnancy to term.

If anyone here can think of yourself as taking turpentine and quinine and taking enough epsom salts that you become dehydrated, or taking black draft that you become dehydrated, and you begin to have bloody stools, then those are the kinds of things that I did to myself because I was determined that I was not going to carry the pregnancy to term. And the fact of the matter is that at that point in my State of mind, I was really literally willing to kill myself than to go to term.

And after the abortion, I almost did die, because I did hemorrhage, and I hemorrhaged a long time, but I did not go to a hospital. I went home to Alabama. I went home to my mother. I did not go to a hospital.

So you see, when Congressman Hyde talks about mental stress, Congressman Hyde has never been pregnant; Congressman Hyde has never missed a period; Congressman Hyde does not know the

mental State that it takes for a woman to decide that she is going to have an abortion, and he does not understand that you can make abortions illegal here—we can go back to the times of the back alleys, and we can go back to when there were no abortions—but women have coat hangers, and women have knitting needles, and those same little knitting needles that you look at and say, "Oh, knit me a sweater or knit me some booties," those are the instruments that women use upon themselves.

Nobody thinks about a perforated uterus. Nobody thinks about a septic abortion. But those things do happen, and they did happen. And yes, I could have died, but thank God I didn't, because I now have three other children to go with my son, whom I had at the age of 18.

Thank you.

Senator METZENBAUM. You are very eloquent and very moving. Thank you very much.

Ms. MOSLEY. Thank you very much, Senator.

Senator HATCH. I don't know of anything that is as difficult as these problems, and I am very concerned about them. In the case of you, Ms. Matulus, I was moved by your testimony in 1982. I was chairman of the Constitution Subcommittee, and we held I think the most extensive hearings on abortion that were held. And, there are good arguments on both sides.

I think the President, when he said that he is for abortion to save the life of the mother, for rape and for incest, has gone farther than almost any President has ever gone on this issue.

And, in your case, Ms. Mosley, my heart goes out to you, there is no question about it.

I am rapidly coming to the conclusion that we have got to do more with regard to family planning and not have to be confronted with abortion. Now, there will naturally be some exceptions, but I think we've got to do a better job with family planning in this country. And it bothers me because the principal family planning group in this country is also very pro-abortion. So it may be that we've got to consider those facts and find some better way of helping young women like yourself, Ms. Mosley, to be able to face the problems that come when you start into your teenage years.

We've got to do a better job of education and helping people. Almost everybody, except for the 20 percent who are against abortion for any reason almost, and the 20 percent who are for abortion for any reason, almost everybody else in this society is tremendously concerned about this issue because it does involve the most important moral and ethical and medical issues facing us today.

I don't want people to go through what either of you have gone through, or Mr. Friedl, what your mother went through. I have read your testimony——

Mr. FRIEDL. Senator Hatch, I am 50 percent disabled with my hearing, and I have understood very little of what has gone on this morning.

Senator HATCH. I see.

Mr. FRIEDL. Could I ask for the assistance of Julie to come up here?

Senator HATCH. Yes, you bet.

Senator METZENBAUM. Of course.

Senator HATCH. Let me make one other comment. I don't know what the answer is to resolve this problem. I feel very deeply about human life, and I think anybody who knows me, knows that. But, I also feel very deeply about personal suffering like you folks have gone through, and I do think we are going to have to get intelligent back here and start thinking of better ways of providing family planning services. I think that could be a large answer to this if we do.

But in the meantime, there are tremendous arguments on the other side as well. Both sides are very sincere, both sides have arguments that have to be listened to. And that is one reason why I am staying and listening to the testimony here today. I am not going to ask any questions. I just want to tell you both that my heart goes out to you. And, I imagine you have gone through hell every day of your lives because of these problems.

Thank you.

Senator METZENBAUM. Ms. Matulus, did you want to say something?

Ms. MATULUS. I just wanted to say, Senator Hatch, that one thing that might go a very, very long way toward resolving at least a great part of this problem would be the development in this country of the RU-486 pill.

Senator HATCH. Well, I don't know that that solves it either. That still doesn't take away the concern of millions of very sincere people who don't want to see human life destroyed. And maybe the best way is to make sure that it doesn't come into existence to begin with because of good planning, because of good family planning methods.

I have very sincere and very deeply-held feelings and convictions, as to many, many others, millions of others, in this country, about the widespread abortion that is going on in this country. It is a serious problem. It is a problem that debilitates society, and yet your problems are real, too, and we've got to look at both sides of this as best we can.

I am very concerned about our society and the insensitivity that many—not yourselves—but many do have toward human life in this country because of this great abortion debate that has gone on for years, a lot of which has been allowed to go on because we as politicians do not resolve these problems. Let's hope we can do that.

I hope these hearings—and I want to compliment Senator Metzenbaum and others in the majority for holding these hearings—let's hope these hearings will help us to arrive at some conclusions that might be more acceptable to everybody in our society, or at least almost everybody in our society, before we are through.

Senator METZENBAUM. Thank you very much, Senator.

Ms. MOSLEY. Senator, may I just ask Senator Hatch a question?

Senator HATCH. Sure.

Ms. MOSLEY. I appreciate your remarks, Senator, but I just want to say one thing. My youngest son is 19, and I call him my "foam and condom baby". The point that I am making is that no birth control method is absolutely 100 percent safe——

Senator HATCH. I agree.

Ms. MOSLEY [continuing.] There are failures. His name is Adam Mosley, and I call him my "foam and condom baby" because believe it or not, my husband was using a condom, and I certainly was using foam.

Senator HATCH. Are you glad you didn't have an abortion with regard to Adam?

Ms. MOSLEY. I love him, and I love my three other children, and I never thought about that at that point. I was an older woman, and I had a husband, and I was more settled within my thoughts.

But I will say one thing about that, Senator. It was a tough decision. I love him. I never thought about it. But I was an older woman at that point, and I think that a woman should have a right to abort if that is her choice.

Senator HATCH. I understand your position.

Ms. MOSLEY. And that was not my choice at that point.

Senator HATCH. I understand your position.

Senator METZENBAUM. Mr. Friedl, we are very happy to have you with us, sir, and I would like you to proceed with your statement.

Mr. FRIEDL. Senator Metzenbaum, I would like to preface my remarks briefly, if I may, to say that I have understood very little of what went on this morning other than what the distinguished congressmen said, and I hope that anything in my written statement or my statement here will not be interpreted as overlooking or ignoring something that might have been said here, because I did not understand it.

Senator Metzenbaum and honorable Senator Hatch, I am singularly honored by your invitation to bear witness before your distinguished body, and I am overwhelmed by a duty to speak out for the uncounted tens of thousands like me, orphaned by illegal abortion.

I will speak more to your heart to be a voice for those disenfranchised infants, toddlers and children living on Guam and in Idaho, who are just now being orphaned by illegal abortion.

Poignantly, my mother's life might have been saved by a country doctor from Idaho, Dr. C.A.B. Jensen in Mackay, ID.

I beg you to save the lives of these mothers now in the same tragic circumstances as my mother was, whose crime must be that they would live, live to care for their living children, than die to carry an unwanted pregnancy to full term.

What is their crime and sin? I see my mother asking me at 4 years old, "Jimmy, who do you choose to take my place if Mamma has to leave you forever? No, Jimmy, you can't choose Aunt Irene because she is Daddy's sister. No, Jimmy, you can't choose Aunt Gladys, because she is already married and has three children."

I now hear the pro-life voices say orphans really can't choose; they don't know what is good for them.

You orphan kids should get down on your knees and thank God he didn't let your mother live to go to jail. Would you choose to keep a mother and bear the sin who terminates her unknown fetus just to live and care for you and your sister? You betcha, brother, you betcha. Just give me back my mother.

During 1929, a gifted soprano, 28 year-old Denver mother, and adored wife of two toddlers two and 4 years old, desperately faced a new and life-threatening pregnancy, unknown to her husband and her parents. She telephoned her desperate circumstances to her

sister-in-law, married to a country doctor in Idaho, and begged her to get "Doc" to perform an abortion.

My aunt gently and sorrowfully told her that she could not ask "Doc" to forget his Hippocratic Oath and professional license to perform an illegal operation, even for one so dear as his young sister-in-law, and "Doc" never heard of her pleas before she died.

My cornered, frantic mother turned to back alley means and illegally obtained a quantity of a controlled drug, ergot apiol, which she secretly and ineptly overdosed at home.

At the dinner table that night, she went into convulsions and died on the floor, before the terrified eyes of her husband and tots, before her grieving husband in panic realized what had hit us and nearly tailspinned into bankruptcy because attendant expenses nearly bankrupt us.

I am the surviving orphan son and my sister is the surviving orphan daughter of that needless tragedy; the subsequent night terrors until I was nearly adolescent, especially needless in light of present laws, because a medically safe abortion could have been performed at her early stage of pregnancy.

My sister and I grew up believing our mother died from ptomaine poisoning caused by home-canned sweet corn—understandably, an equally painful and horrible death, but socially acceptable to the pro-lifers of 1929 and 1990.

We never had a chance to ask our Dad, his sister and our uncle "Doc" for the facts, which we learned only 2 years ago, when my sister, a retired nurse, researched and obtained a copy of my mother's death certificate, which is attached: "Cause of death, determined by an autopsy, overdose of ergot taken to produce an abortion."

Honorable Senators, we, none of us, ever mourned for an instant the unborn, unnamed, unknown brother or sister fetus, also lost from that abortion.

Has anyone, pro-life or pro-choice, seen orphans massed in protest? Unseemly and unthinkable. Infants and children cannot organize and mass-demonstrate effectively, consciously or unconsciously regarding each self as an unwanted epithet, orphan, and orphans don't count. So orphans are uncounted and discounted in this battle to save mothers, which affects/effects those survivors most directly and hardest of all, since each orphan knows himself a lesser person—else, "Why did Mommy leave me?"

At the age of 14, I spent a summer in the tiny rural agricultural town of Mackay, ID with my aunt and uncle "Doc". They owned and operated the only drugstore in perhaps 100 miles, and uncle "Doc" was the pharmacist, the family doctor, the surgeon, the veterinarian practitioner and oral surgeon—the only medical professional during the snowed-in months from September through April, making his rounds by horse-drawn sleigh.

I swept the floors and tended the soda fountain. Uncle "Doc" played classical music on his grand piano located in the display window, for relaxation, and to keep his hands supple for surgery. He could also light six out of ten bonfire matches with my open-sight, single-shot .22 rifle at 25 paces from the back stoop of his medical office behind the drugstore. So nobody laughed at him much, and I was totally over-awed.

One afternoon he stepped out of the office with a young patient and, reaching for a pint of whiskey from the store shelf, he handed it to his patient with instructions. He tossed me the keys to my aunt's brand new Studebaker President and instructed me to drive Steve home and bring him back the next day, same time.

I called for him at his miner's shack, but he was so drunk I had to help him to the car. I was half afraid what uncle "Doc" might say or do, since he was also the town justice that year. Later that afternoon during target practice, uncle "Doc" explained that Steve was dying with diabetes, and uncle "Doc" was pulling one tooth per week from his shredding gums. A pint of whiskey was the anesthetic; Doc Jensen was the sole medical professional in attendance. He never had a clinic or a hospital within 200 miles.

My aunt told me the facts of my mother's tragic death in my early 20s. "Doc" was long gone from exhaustion. I had no chance to ask him, if my mother had asked him one-on-one, would he have denied her, regardless of his medical vows. Looking back on my personal summer relationship, I cannot believe this greatest humanitarian would have said no.

In my 65th year, I now comprehend my childhood envy and hungry yearnings at the sights and scenes of my cousins nestling in the intimate embrace of my maternal aunts, their natural mothers, which I could see and "feel", if you will, but never touch, or hold to myself, not even for an instant, naturally.

That, honorable Senators, you will recognize as the nature of nurture, forever denied orphans, our outcasted legacy of illegal abortions.

Thank you for hearing me.

[Attachments of Mr. Friedl follow:]

April 11, 1989

NATIONAL ABORTION RIGHTS ACTION LEAGUE
1101 14th Street, N.W., 5th Floor
Washington, D.C. 20005

Attention Kate Michelman

My special thanks to you, for including me in the Pro-Choice events.

We feel that orphans, like my sister and I, are an unseen/unheard minority in the PRO-CHOICE vs PRO-LIFE revolution, and we wonder if there are any statistics about us?

We would hope to speak-out for the uncounted multitude (conjectured at tens of thousands annually) of infants, toddlers and "underage" children who lack our lifetime survival experiences to hard-shell, digest and focus their daily experiences into cogent, mature expressions and most lamentably, they lack any elected representative in the U. S. House or Senate.

The following incident displays the contemporary prejudice in the matter: A woman newspaper reporter, who interviewed me after the Voices for Choice dinner remarked: "Oh, then; you aren't REALLY an orphan", when she learned my father (unfortunately?) also survived the illegal abortion which took my mother. I suggested she check her dictionary, as I did, when I took the orphan EPITHET.

My being, since childhood, was again seared by her unfeeling remark which starkly implies: "you MERELY lost your mother!..." Isn't that a firm, Pro-Life tenet?...Akin, I submit, to my cousins' and playmates' taunt, as I was later taught to call my step-mother: Mother..."Oh; but she isn't your REAL mother!"

Can you picture the orphan waif, ala a Norman Rockwell, forlornly gazing at a natural mother nesting her two children in a loving embrace - NATURALLY, there's no mistaking the NATURE of that intimacy! - it would be captioned: The NATURE of NURTURE; BUT it's not for you!

We all look upon that scene almost daily, it seems to me. Maybe you've never noticed.

If I am not an orphan, Kate, then my mother's death from an illegal abortion truly counts for nothing and you will, please, strike my name from your rolls.

I'd like to close by sharing my feeling that the chance to rub intellects with the likes of you and your warriors, truly sparks my enthusiastic interest in this matter.

Warmest regards,

Jim G. Friedl

Jim G. Friedl
USMC (Retired)

CERTIFICATION OF VITAL RECORD

STATE OF COLORADO

STATE OF COLORADO
Bureau of Vital Statistics
Certificate of Death 16, 8023

1 PLACE OF DEATH

County Denver. 177 File No.

Town Denver. Registration District No. Registered No.

or City No. St. Ward
(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Ruth Irene Friedl.

(a) Residence. No. 4885 Irving St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

(b) Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Adolph Friedl.

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1901.

7 AGE: Years 27 | Months 11 | Days 27 | IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Iowa.
(State or country)

PARENTS

10 NAME OF FATHER W.H. Maine.
11 BIRTHPLACE OF FATHER Ill.
(City or town)
(State or country)
12 MAIDEN NAME OF MOTHER Emma Rosson.
13 BIRTHPLACE OF MOTHER Ill.
(City or town)
(State or country)

14 Informant Adolph Friedl. husband.
(Address) 4885 Irving St.

15 Filed Aug 25 1929 J.M. Grant Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug. 21, 1929.

17 I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...
that I last saw ... alive on ... 19...
that death occurred, on the date stated above, at ... m.
The CAUSE of DEATH* was as follows: 177
Abortion Erysipelas
to produce an abortion

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Crown Hill.
DATE OF BURIAL: Aug. 28 1929

20 UNDERTAKER Hofmann Nursery.
ADDRESS

THIS IS TO CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD WHICH IS IN MY CUSTODY.

DATE ISSUED JAN 19 1989

JOSEPH D. CARNEY
STATE REGISTRAR

Do not accept unless prepared on security paper with engraved border displaying the Colorado state seal and signature of the Registrar. PENALTY BY LAW, Section 25-2-118, Colorado Revised Statutes, 1982, if any person alters, uses, attempts to use or furnishes to another for deceptive use any vital statistics record. NOT VALID IF PHOTOCOPIED.

VR 1005 A/88

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

STATE OF COLORADO 1876

Senator METZENBAUM. Thank you very much, Mr. Friedl.

Your testimony as well as that of each of the other two witnesses this morning has been just tremendously powerful.

It is my understanding that you lost your hearing at Iwo Jima; for that, we all express our gratitude to you. We express our gratitude to you for having the courage to stand before us and tell us about your mother's tragic loss of life, its impact upon your life and your sister's life. It is not easy to make that kind of a statement before a Congressional committee. I appreciate your comments very much and your testimony.

I thank you, and I have no questions.

Senator Hatch.

Senator HATCH. Thank you. We are glad that you came, and we are happy to have all of your testimony.

Again I just want to say if President Bush had his way, certainly rape and incest would be an included exception to any abortion restriction. And, I believe that there is certainly a swing toward that that would resolve a lot of problems in our society, and I have made my comments about family planning; I hope that we can somehow or other do a better job than we are now doing.

Thank you all for coming and testifying.

Senator METZENBAUM. Thank you.

I would just like to make one comment in response to my colleague. That is, if the President had his way, there would have been an answer for Ms. Matulus. There would not have been an answer for Marilyn Mosley, there would not have been an answer for James Friedl's mother; those were not cases of rape and incest. And with family planning, I am not at all certain that Marilyn Mosley, Mr. Friedl's mother would have had any different result. I don't know the facts about Mr. Friedl's mother, but I would guess that with respect to Ms. Mosley, that the result would not have been different.

I too am a supporter, a strong supporter, of family planning legislation and believe we need it, but I don't believe that family planning legislation and permitting abortions in the case of rape or incest only, will solve this very, very, very critical problem in this country. I think those who think it will are kidding themselves, and I think that we ought to work together to draft a piece of legislation that makes it possible for women who want and need an abortion to have a right to choose for themselves, and that we who sit here as Senators or Congresspersons or even judges not make that determination for them.

Thank you very much.

Senator HATCH. If I could just say one thing—as I understood it, Ms. Mosley, your first pregnancy was when you were 13; you were raped by a border. That's the information that we have.

Ms. MOSLEY. Yes.

Senator HATCH. That's why I referred to both of you in that with regard to rape.

But then, at age 20, you were pregnant again, and that's when you tried to abort yourself with knitting needles.

Ms. MOSLEY. Yes, I did.

Senator HATCH. OK, thank you.

Ms. MOSLEY. Thank you.

Senator METZENBAUM. Thanks to each of you. Your testimony was very, very helpful.

Our next witness is Ms. Gabriella Bocec, who was the Deputy Director of Post-Basic Education at Bucharest, Romania.

STATEMENT OF GABRIELLA BOCEC, DEPUTY DIRECTOR OF POST-BASIC EDUCATION, BUCHAREST, ROMANIA

Ms. BOCEC. I am here today to share with you my experience as a woman and as a nurse in this effort to help the American woman in this very critical problem.

I am very impressed by the testimony presented by the two ladies before because what happened in the United States 20 years ago happened in Romania until the uprising in December 1989.

According to our law against abortion, women could obtain abortions if they were 45 years old and already had five children. But this law had such terrible consequences that the major slogan during the uprising in December 1989 was "Liberty, democracy, and abortion", and there is not any evidence that now one party will ask to be against this law.

The result is that almost the first action of the new government was to change the abortion law. We cannot forget the consequences of the Ceaucescu law—young people losing the possibility of having children in the future because, having unplanned pregnancies they could not manage, they went to some untrained, unskilled woman for illegal abortions. And because they came to hospitals, doctors had to perform hysterectomies so that they could not be mothers again, because their lives had to be severed at that moment. And quite a lot of women died.

According to the World Health Organization, in the mid-1980s, almost nine in ten maternal deaths were related to abortions in our country. And only in the first month after this new law, deaths from abortion fell by more than half.

We have not to forget the orphaned children. The average woman dying from illegal abortion left 2.3 children. And I can say to you that between 1982 and 1988, 6,811 children were left motherless from abortion.

In most cases, these children went to orphanages, malnourished, not nurtured, sickly, often given blood transfusions for health reasons, and many of them are now with AIDS. And I have read just today in your newspaper that situation, and it is the real situation.

And we have not to forget the increase in congenital abnormalities. Because law prohibited abortion for women under 45, increase in number of children with congenital abnormalities number rose 50 percent from 1985 to 1988 (6,032 in 1985 to 9,385 in 1988).

If you are going to have such a law, you have to enforce it. In Romania, we realized this by periodic examinations done by doctors sent to factories, and as women, we felt an invasion of our privacy. And if you have been pregnant, officially you have been recorded, and there is no escape.

So that the woman has two choices—self-induce or go to someone else. Rich woman can go to another place and find a doctor to perform the abortion; but what happens with the poor woman? They have to go for an illegal abortion to some unskilled person.

If a woman were found to have had an illegal abortion, there were two options—to say to the commission who had performed this abortion, and in this case, that person was sent to prison; or maybe to go herself to prison, often leaving young children at home.

And if a woman came to the hospital after an illegal abortion, it was always at the last minute, because she was afraid of being found out and at the same time, she was examined by a "commission"—and this commission included not only doctors, but police and magistrates—and only if the life of this woman was under the question mark was the abortion performed.

Let me tell you only one story. There was a man whose sister died from a criminal illegal abortion, and now his wife is pregnant. She had an abortion, and she died. And when they came home after the funeral, the oldest of the children asked, "Father, will you send us to the orphanage like uncle has sent our cousin?" And he said at that moment, "No." But can you imagine a young person with three children, one of 10 months, another of 3 years, and the other of 7 years—do you know what that means for him because he cannot receive any medical leave when the children were sick? The father can't get time off from work, only mother is given time off from work to care for children.

In conclusion, I will say to you that it would be virtually impossible to design a problem that would have a worse effect on maternal and infant mortality on the health of the women and the well-being of the families than the policy in Romania under the Ceaucescu regime. Under this policy, infant and maternal mortality soared, as did the number of motherless and abandoned children.

Even if you have very good family planning, you will have unplanned pregnancies, and you cannot prevent abortion by making the process illegal. Even if abortion were illegal, some women would always have unwanted pregnancies, and if they are rich, they can go abroad to another State—but if they are poor, they will have no other choice than to go to these untrained persons.

As a nurse, I cannot forget the helpless feeling that comes over us watching a woman dying following such a criminal abortion. And after all this, the terrible responsibility to say to the husband and to the children that their wife and their mother just died.

I will stop there.

Senator METZENBAUM. Thank you very much, Ms. Bocec. I appreciate your testimony.

Now, as I understand it, you were and are the Deputy Director of Post-Basic Nursing in Bucharest, Romania?

Ms. BOCEC. Yes.

Senator METZENBAUM. And you work at the Municipal Hospital?

Ms. BOCEC. No, I am not working at the Municipal Hospital. I am involved now in the new Association of Family Planning in Romania. But I am going for practical training with nurses in any hospital in Romania so that I am informed.

Senator METZENBAUM. And in your past experience, you have seen the extent of illegal and self-induced abortions among Romanian women where the law of the land made abortion illegal; is that correct?

Ms. BOCEC. Yes.

Senator METZENBAUM. According to one report in the *New York Times*, abortion accounted for 86 percent of all maternal deaths in Romania. That means that nearly nine of every ten women who died of complications due to pregnancy died because of illegal abortion. Do those numbers sound correct to you?

Ms. BOCEC. Yes, it is very correct. It was done by the World Health Organization, who was in our country to study the situation.

Senator METZENBAUM. I am going to insert in the record some statistics from the Ministry of Health in Romania, reporting the number of deaths related to abortions in each year since 1965. The figures show that many women died needlessly from complications associated with illegal abortions. For instance, in 1966, the year before abortion was outlawed, 64 women died; but in 1967, when abortion was no longer legal, that number more than doubled to 143 deaths.

Ms. BOCEC. Yes.

Senator METZENBAUM. And the trend has continued upward, so that by 1989, 545 women died in a single year from complications related to illegal abortions.

Ms. BOCEC. Yes, that is correct.

Senator METZENBAUM. Are these figures correct as you know them to be, and do they conform with what you understand has been occurring in Romania?

Ms. BOCEC. Yes, that is correct. They are done by the Ministry of Health. This is the reality. And looking at that data from 1989 and at the other data from January 1990, you can see how it has dropped, the death of the mother.

[Articles from *New York Times* follow:]

Glasnost and Sex

1-23-90 MT

By Dmitri N. Shalin

CAMBRIDGE, Mass.

Surely, sex in the Soviet Union predates perestroika. But the eroticization of popular culture now afoot has glasnost written all over it.

New portents are everywhere: a pictorial in Playboy magazine on "The Women of Russia," an erotic art exhibit in Moscow, a nude-photograph show in Leningrad, a special on sex in the U.S. cinema at the 16th International Moscow Movie Festival.

The latter event created quite a stir among Muscovites. A flashy guide printed for the occasion featured on its cover nude photos of Marilyn Monroe and Natalia Negoda, a rising Soviet star. Many moviegoers left disappointed, however. American classics of the 60's and 70's looked tame compared with what Soviet cinema has to offer these days.

There is "Little Vera," a path-breaking picture about changing mores in a provincial Soviet town. Another crowd-pleaser is a movie version of "Lady Macbeth from Mzensk," which features explicit sex scenes that would earn solid "R" ratings anywhere in the West. My favorite is "Local Emergency," a bitter satire about the Communist Youth League, featuring a sauna scene with youth organizers mulling over business amid a sex orgy.

Soviet theater doesn't lag far behind. Nude actors and actresses now routinely strut their stuff before gasping audiences. Even stodgy Russian classics are no longer immune to novel treatment. Last summer, for example, a 19th century play known to every Soviet high school student, "Enough Simplicity for Every Wise Man," shocked the viewers with nude scenes. Soon, a critic for Literaturnaia Gazeta said recently, there will be no audience for any show without "an obligatory copulation scene."

Dmitri N. Shalin is a visiting scholar at the Russian Research Center at Harvard University.

> The new openness has started a belated revolution.

The popular press is also scrambling to keep up with the times. Premarital sex, contraceptives, abortion, venereal disease, prostitution and like subjects once considered taboo are now open for public scrutiny.

With premarital sex increasingly common among Soviet youth (two-thirds lose their virginity by the age of 21), unwanted pregnancies and sexually transmitted diseases are turning into a serious problem.

According to the Communist Youth League newspaper, Komsomolskaia Pravda, 6.5 million abortions were performed in the Soviet Union in 1988. If this figure is right, one out of 10 Soviet women of child bearing age terminated a pregnancy that year. Roughly one-fifth of all abortions involved teen-agers.

The main reason for these gruesome statistics is unreliable or nonexistent contraceptives. Diaphragms come in only three sizes. There is no spermicidal cream. Condoms are in short supply. Last year, according to Komsomolskaia Pravda, "one item" cost 4 rubles, or $8, on the black market. Now, the price is closer to $10. No wonder abortion remains the chief birth-control option.

Venereal disease is a growing nuisance. Cases of sexually transmitted disease in Moscow tripled between 1982 and 1986 and continue to rise.

One fresh concern is AIDS. The problem is not nearly as severe as in the West (only a few dozen officially reported AIDS-related deaths so far), but this simply reflects the country's late start on the sexual revolution.

Carriers of any sexually-transmitted diseases are considered criminal offenders under Soviet law and face forced hospitalization. Thus, since many victims understandably shy away from help, the official numbers understate the problem.

Prostitution attracts particular attention in today's press. The problem is an old one, but with a new twist. Sovetskaia Kultura, a weekly newspaper, reports that girls as young as 13 and 14 now find their way into the profession. By last year the situation had gotten so much out of hand that the Education Ministry felt compelled to issue a special decree on prostitution among high school students.

A movie about the life of a prostitute, released last fall and clearly meant as a cautionary tale, has proved counterproductive. The magazine Semia cites a poll in which girls 16 to 18 consider prostitution a prestigious occupation, rivaling in popularity modeling, movie acting and being a professor's wife. "At least I sell what is mine and don't steal from the state," was the widely publicized reply that a young prostitute gave to her parents.

With the country in the throes of this sexual revolution, sexual morality is becoming a political issue. For conservative forces, laxity in sexual matters is an epitome of everything that is wrong with perestroika: lack of direction, self-indulgence, contempt for traditional values. For liberals, the main issue is the state's inability to meet people's basic needs: the very conditions that spurred reform.

Is there anything the West can do to help this hidden front in the battle for perestroika? I think so. Forget about exports of advanced technology. Send condoms, not computers, so that Soviet women can rely less on abortion; donate anesthetics — now in extremely short supply — expressly for abortions, which are often done without even local anesthesia; deliver disposable syringes to allay fears of AIDS infection; bring in family planning and sex education experts.

> Venereal disease abounds, and birth control is rare.

These measures may or may not help Mikhail Gorbachev stay in power, but they would earn the heartfelt thanks of millions in the Soviet Union. □

Ceausescu's Main Victims: Women and Children

By B. Meredith Burke

One of the first acts of the new Rumanian Government, the Council of National Salvation, was to release a 23-point "radical plan" for change. Some outside observers were surprised that the plan included liberalization of the abortion law. They shouldn't have been. Abortion is no minor issue in Rumania.

Before 1966, abortion was by far the main method of birth control, because locally produced contraceptives were shoddy and in short supply, and importation of foreign contraceptives was strictly controlled. In 1965, Rumania had 1.115 million recorded abortions and 274,000 live births. Simply put, 80.3 percent of all known pregnancies ended in abortion.

But President Nicolae Ceausescu, unhappy with the country's crude birth rate of 14.3 per 1,000 people and eager to increase the workforce, abruptly reversed the liberal policy in 1966. If it weren't for the many lives adversely affected by this decision, the immediate results had an almost humorous side. Mr. Ceausescu apparently forgot that before one has more trained workers, one must have more pregnant women, more babies and children to be nurtured. Live births nearly doubled from 1966 to 1967, to 528,000. Factory production went down as a sizable fraction of the workforce took maternity leave.

B. Meredith Burke, a demographer and economist, has consulted for the World Bank.

1-10-90 WSJ

He barred abortion and birth control.

With a low and deteriorating standard of living, Rumanian women behaved predictably. They resorted to illegal abortions. By 1968, the birth rate began the first in a series of declines as abortion networks were clandestinely set up. Between 1967 and 1970, the number of live births declined 23 percent in urban areas and 17 percent in rural ones.

The rise in maternal deaths was also predictable. They went from 235 in 1966 to 481 in 1967 and 506 in 1968. Rumania's maternal death rate was 85.9 per 100,000 live births in 1966, 96.2 in 1968 and 139.9 in 1981. This compares with 9 for England and Wales and 15.5 for France in 1979. In England, 22 percent of maternal deaths were attributable to abortion, against 85.6 percent of such deaths in Rumania. And that figure probably understates the problem. Physicians' reports now coming out of Rumania suggest that many women suffering the complications of illegal abortions stayed away from hospitals for fear of being reported to the secret police.

By 1983, the crude birth rate had dropped precisely to its 1966 level of 14.3. The Government's response was to restrict abortion further, require women to have monthly examinations to determine their pregnancy status, impose a steep tax on unmarried people over the age of 25 or childless couples lacking a medical reason for infertility — and, of course, prohibit the importation of modern contraceptives. Women of childbearing age who lacked proof of monthly examinations were no longer eligible for free medical care and could not apply for, or renew, drivers' licenses.

One Rumanian psychologist reported a notable increase in women with problems related to stress and sexual tension, since withdrawal and prolonged celibacy are the only readily available means of avoiding pregnancy. Obviously, the male half of the population is not immune to such problems, either.

Two indicators of the status of the unwanted children are the infant mortality rate and the number of babies available for adoption. The reported infant mortality rate in 1985 was 25.6 deaths per 1,000 infants in the first year of life, again well above 1983 rates of 7 (Sweden), 9 (France), 10.9 (the U.S.) and 15.6 (Czechoslovakia).

Mothers, babies died in droves.

More significantly, in 1987 Rumania broke with international medical protocol by imposing a 30-day delay in registering births, presumably to avoid recognizing deaths in the first month of life. Since, in a modern country, such deaths are 60 to 80 percent of all infant deaths, Rumania's recorded infant mortality rate would be only 20 to 40 percent of the true rate.

This suggests that infanticide — active or, more likely, passive — was being practiced on a wide scale. Passive infanticide includes delay in seeking medical help for common respiratory and other illnesses, neglect in feeding babies, etc.

Equally strong evidence of maternal rejection is apparent in a 1988 report that Rumanian orphanages were overflowing with abandoned children. Besides, Belgian, French, Israeli and Italian couples were adopting babies for hard currency.

So far, the reported membership of the Committee for National Salvation is largely male. It is a good sign, however, that they are attentive enough to their wives, mothers and daughters to include as one of the first elements of a democratic state the provision of reproductive freedom. I hope that a panoply of safe, effective contraceptives will be among the first items to be imported. Rumanian women can then be liberated from the former repressive practices and the need for a semiannual abortion. □

1/23/90

Where Fear and Death Went Forth and Multiplied

NYTimes 1-24-90

By DAVID BINDER
Special to The New York Times

BUCHAREST, Rumania, Jan. 23 — The dictatorship of President Nicolae Ceausescu caused extreme hardships for all but a few hundred thousand of Rumania's 23 million citizens. But in the case of mothers and babies, his rule apparently had the most tragic consequences.

Mr. Ceausescu, who was ousted in a popular uprising a month ago, decreed in 1967, two years after he came to power, that Rumania's population, then about 22 million, should increase to 30 million. The reason he gave was simply that he wanted a bigger Rumania — an assertion widely interpreted now as an early indication of his megalomania.

And to achieve his goal he banned abortions, made contraception illegal and ordered that Rumanian women of child-bearing age have five children each.

No Precise Accounting

Harsh fines were ordered for women caught having abortions, and doctors or medical technicians who assisted in abortions were sentenced to up to four years in prison and prohibited from practicing for 10 years. In the latter years of the regime, women working in factories were subjected to pregnancy checks as often as once a week.

There is as yet no precise accounting of how many Rumanians were adversely affected by such strictures. Officials of the new provisional Government and outside experts have only begun to gather data about what happened over the years. But the fragmentary figures and educated guesses that they have been able to provide depict a society of families torn by death and fear as a result of the decrees paradoxically meant to make them propagate.

"The policy was a total failure," said Dr. Timothy Rutter, a consultant for Murray Stopes International, a British charity that assists planned parenthood projects. Dr. Rutter spent the last week in Bucharest.

In talks with officials at the new Government's Ministry of Health, Dr. Rutter was told that while the Rumanian population rate grew by 2.5 percent in 1966, in 1989 there was actually a negative growth rate. Rumanian officials said there were 300,000 births last year and 1.2 million abortions.

Jail for Performing Abortions

In Iasi, a city of 400,000 people in northern Rumania, physicians told a visitor that three Iasi University medical professors were jailed for one year each under the dictatorship for performing abortions.

"We have many maternal deaths and very many abandoned children" as a result of the abortion policy, a physician said, adding that in Iasi, medical instruments that might be used in abortions were kept locked up and could be taken out only under the supervision of a state security police officer.

Every Rumanian seems to know cases of mothers dying during botched abortions, children orphaned as a result of such deaths and babies harmed

Ceausescu's birth policies leave a grim legacy.

by unsuccessful attempts at abortion. Officials said there are 718 orphans up to the age of 3 in Bucharest, many in pitiable condition. The officials said that the children were orphaned as a result of the Ceausescu policies and that there would be more had the regime not sold Rumanian orphans to France for hard currency. Presumably the orphans were from families broken after the mothers had died during abortions or during unhealthy pregnancies.

Death of a Wife

In an interview, Ion Tudor, a 48-year-old museum worker, told of his family with tears in his eyes. In February 1975, he came home from a work assignment in another city to find his 28-year-old wife, Florica, in a state of collapse.

"She had gotten an abortion from a medical technician," he said, adding that he had no knowledge of her plans. "I called an ambulance. It took 12 hours for the ambulance to arrive. We went to the Giulesti Maternity Hospital. They called the police, who said she could not receive treatment until she confessed who had performed the abortion. She received no care for two days. Then she had a kidney collapse.

"The doctors sneaked her over to the Emergency Hospital, where the doctors treated her. The doctor there told me if she was strong she had a chance to live. She died 18 days later."

She left Mr. Tudor with three sons, ages 2, 4 and 8.

Mihai Orovanu, a Bucharest photographer, told of visiting an archeological site at Pacuiul Lui Soare, near the Danube, last November and finding a Bucharest physician living in a cave. He had been jailed and then barred from practice for 10 years because he had performed abortions. "He was living off vegetables he stole from the fields and fish he caught in the river," Mr. Orovanu said.

'There Was No Milk'

The babies who were born faced severe hardships. Christian Modoicu, a 39-year-old foreign trade specialist who has two children, said he and his wife decided not to have any more. "We wanted a third child, but there was no milk to be had," he said.

During the Ceausescu regime, intrauterine devices and condoms were traded on the black market, with American-made I.U.D.'s selling for more than $100 apiece. But such devices were scarce.

In Bucharest there are 20,000 women in hospitals being treated for abortion complications, Dr. Rutter said, quoting the Rumanian health officials. He said an additional 10,000 Bucharest women are waiting for places in hospitals for treatment of blocked fallopian tubes caused by mishandled abortions. Abortions are being performed at a rate of 60 a day at one Bucharest hospital alone. Condoms are now becoming available in the capital's pharmacies.

Senator METZENBAUM. Now, another article in the *Washington Post* reported that last year at Bucharest Municipal Hospital alone, 3,000 women were treated for complications due to failed illegal abortions. Are those figures accurate, according to your best information?

Ms. BOCEC. I cannot tell you the real data, but I know that there are quite a lot in any hospital, not only in Bucharest, but in all the districts, and you can face such a dramatic situation, seeing at the door of the hospital the family, inside, this poor woman who is trying to live because she knows that she will leave her children, with the nursing personnel and the doctors involved, doing everything in order to keep her alive—but sometimes, as I told you, death occurs. And you can imagine how hopeless we feel because we want to give this mother the possibility to go home.

And this is why you must understand that this new law offers to us the opportunity in some desperate cases—it will start with family planning, too, but even if you are using this family planning, sometimes unplanned pregnancies happen. And you have to give the possibility to a woman who has two, three, four children, to have her choice.

Senator METZENBAUM. Some news reports stated that the women, when they came to the hospital, were questioned by committees made up of police and prosecutors before they were given treatment. In your experience, did women avoid seeking medical treatment out of fear that they would be questioned and punished for having an illegal abortion?

Ms. BOCEC. Yes, they are afraid. They are afraid first of all because they are punished. They are afraid to say if another person had performed this abortion, to say the name, because if it was a doctor, he would be not only sent to prison, but he would lose the possibility to practice his profession. And he is of course not at ease to discuss a commission what is not already done only by doctors, because as I told you before, a magistrate is on this committee, and the policemen, and they put always the questions: Who has done it, what has been done, and so on. For us, this makes the case more difficult because sometimes when we know what was the substance used for this abortion, you can use an antidote and solve the problem; but sometimes they don't say to us, although they suffer very much and you can save them, but they don't want to say it.

Senator METZENBAUM. As I understand it, the restrictive policies on abortion and contraception had profound effects on the children of Romania as well. Reports show that the infant mortality rate in Romania—infant mortality rate—rose from 20 deaths per 1,000 live births in 1970 to almost 28 deaths per 1,000 in 1989, a tremendous increase, a 40 percent increase to be specific. Is that correct?

Ms. BOCEC. That is correct.

Senator METZENBAUM. And what generally happened to children of women who died from illegal abortions?

Ms. BOCEC. When they woman died, there were some cases where the family tried to keep the children, but usually they are sent to orphanages. And not all the children from the orphanages can be adopted, and they remain there. And from those children, malnourished, you have seen in your newspapers that they now have AIDS

because they received blood transfusions in order to make them healthier. But they receive, instead of this, the virus.

Senator METZENBAUM. The AIDS virus.

Ms. BOCEC. Yes.

Senator METZENBAUM. And the government arranged for monthly pregnancy tests of Romanian women at their jobs. Were those tests also used to detect women who were using contraceptives illegally?

Ms. BOCEC. Yes. You know, they had to reinforce this law, and this happened in 1986. They started then to say that they had to have five children, because before it was sufficient to have only four children, and from that moment they put like a regulation that the doctors go to factories to check if the women are pregnant or not.

Senator METZENBAUM. I will include in the record at this point a record of the number of abortion-related deaths in Romania.

[The information referred to follows:]

MINISTERUL SANATATII

CENTRUL DE CALCUL SI STATISTICA SANITARA

(MINISTRY OF HEALTH—ROMANIA)

Decesels Prin Complicatiile Sarcinii Nasterii Si Lauziei

Year and Number of Abortion Related Deaths: 1965—47, 1966—64, 1967—143, 1968—192, 1969—258, 1970—314, 1971—363, 1972—370, 1973—364, 1974—381, 1975—385, 1976—432, 1977—469, 1978—447, 1979—422, 1980—441, 1981—456, 1982—511, 1983—471, 1984—449, 1985—425, 1986—488, 1987—491, 1988—524, 1989—545, January 1990—20.

Senator METZENBAUM. Senator Hatch.

Senator HATCH. Ms. Bocec, I am not sure I caught all your testimony, but it is my understanding that under Ceaucescu, he really required that women have at least five children; is that correct?

Ms. BOCEC. Yes.

Senator HATCH. It actually was compulsory in your country.

Ms. BOCEC. Yes.

Senator HATCH. But after they had five children, then they could have abortions if they wanted them——

Ms. BOCEC. Yes.

Senator HATCH [continuing.] And they could have abortions any time they wanted them.

Ms. BOCEC. Yes. But you know, in Romania it is quite difficult to have five children.

Senator HATCH. I understand.

Ms. BOCEC. At that time, from the income point of view, from the point of view that the mother has to go to work outside and other reasons——

Senator HATCH. I agree, and I don't have any problem with that. But in Romania, as I understand it, under Ceaucescu, you had no family planning or contraceptive services.

Ms. BOCEC. Not at all.

Senator HATCH. In other words, that was forbidden.

Ms. BOCEC. It was forbidden.

Senator HATCH. It is my understanding and according to the news reports in the United States, it is said that there were compulsory pregnancy programs.

Ms. BOCEC. Yes.

Senator HATCH. And is it also true that women were routinely monitored to see if they were pregnant?

Ms. BOCEC. Yes.

Senator HATCH. That was part of Ceaucescu's reign.

Ms. BOCEC. Yes.

Senator HATCH. And is it also true that contraceptives were illegal under his regime?

Ms. BOCEC. Yes—only on some medical advice, with the permission of one special commission, they can receive contraceptives; but only in these cases.

Senator HATCH. Well, that was quite a regime is all I can say. And, all of those things are, of course, very contrary to our policy in this country, as you can imagine. So again, my heart goes out to you and the people of Romania.

Also I just want to mention as a postscript that I am very concerned about the AIDS problem over there with your children. They just use and reuse those needles until they've got young children who now have AIDS. It is a terrible problem.

Ms. BOCEC. It is terrible. And as you can notice from the newspaper, they are not only with AIDS; they are malnourished. And this is why the epidemic just bloomed so quickly, and this is why we need to be helped. You see, at the moment, we have not even milk power——

Senator HATCH. I have made a lot of efforts to see that we are able to provide Romania with AZT for children, which is a drug developed here that alleviates some of the difficulties with AIDS, especially if you catch it early. It was so difficult to get in there and get past the bureaucracy—we had it all set to be able to bring that over there for those children—and it was so difficult to get past the bureaucracy, and presently, even with Ceaucescu gone, apparently there is still a lot of corruption. I would like to be able to help bring that about and help the children.

Ms. BOCEC. We would be very happy.

Senator HATCH. I thank you. I appreciated your testimony, and I just want you to know that it is different here, even though there is a lot of concern about how best to handle this issue.

Thank you for your testimony.

Ms. BOCEC. Thank you.

Senator METZENBAUM. Thank you very much.

Senator Coats.

Senator COATS. No real questions, Mr. Chairman.

Thank you for your testimony. I guess the point to make here is that we are dealing with two somewhat different situations. If I understand your testimony correctly, the cause of many of the abortions and resulting impact on illness or in some cases, the tragic death of the mother, was precipitated by an act of government which actually penalized those who were not conceiving, and in a sense forced unwanted pregnancies.

Ms. BOCEC. Yes.

Senator COATS. Whereas there is no direct government act, law or whatever, forcing unwanted pregnancies. You have the tragic result of unwanted pregnancies, not dictated by the State, but dictated by cultural practice and so forth. So there is a significant distinction, I would assume, that you are drawing between cause and effect relationship in Romania in the previous regime and cause and effect relationship here in the United States.

Ms. BOCEC. Yes, but to be sure—if you have very good family planning, you still will have undesired, unplanned pregnancies. What will happen—not for the rich women—but for the poor women—because this was the situation in our country.

Senator COATS. I understand that. I just wanted to make sure I understood the distinction between practices that you have described which result in, in a sense, State coercion to bear children, and many bearing children even though they did not want to bear them.

Ms. BOCEC. Yes. And I think, because I am a woman, that a child has first of all to be loved if you want to have a healthy child. To be loved means to be desired.

Senator COATS. Well, I understand that, but there are certainly a lot of children who are born into this world who aren't necessarily loved and don't come along at the right time. Love is an act of personal commitment. If we are simply going to eliminate those in our society who are not loved, I am afraid all of us stand in some jeopardy, depending on who makes the decision.

Ms. BOCEC. And as a nurse and as a woman, I can say to you that they need love as much as maternal milk.

Senator COATS. Oh, I couldn't agree with you more.

Senator METZENBAUM. Thank you very much, Senator Coats, and thank you, Ms. Bocec. We are happy to have you with us, and I might say to you, before you leave to go back, that perhaps my staff and Senator Hatch's staff could help and see to it that AZT is made available to the children of Romania.

Ms. BOCEC. I hope so. Thank you very much.

Senator METZENBAUM. We'll be glad to try to help, and I think we can.

Ms. BOCEC. Oh, yes. Thank you very much.

Senator METZENBAUM. Our last panel includes Dr. Herbert Jones, M.D., Charlottesville, VA; Dr. Louis Gerstley, II, M.D., of Wyncote, PA; and Shari Richard, Union Lake, MI.

Dr. Jones, please proceed. You know of our 5-minute rule.

STATEMENTS OF DR. HERBERT JONES, CHARLOTTESVILLE, VA; DR. LOUIS GERSTLEY, III, WYNCOTE, PA; AND SHARI RICHARD, UNION LAKE, MI

Dr. JONES. Thank you, Senator Metzenbaum. I appreciate the opportunity of appearing before your committee on this very serious subject.

No one likes an abortion, or even to discuss it—certainly not the patient, the physician, the partner, nor the public, and certainly not now, the politicians. It should remain as a private matter between the patient and her physician.

It is not an easy decision for the woman or for her physician provider.

I am a physician with a practice that gives the woman complete care except for obstetrical delivery. Terminations of pregnancy are simply one component of gynecologic care.

In the past, I have done obstetrical deliveries, and I have helped place over 300 babies for adoption. And I believe this to be a good alternative for the unwanted pregnancy, but not the only alternative, and it cannot be forced on teenagers or adults.

I remember a woman, a poor soul from central Virginia who, in her deep anxiety, to rid herself of her pregnancy, died after giving herself a douche of bichloride of mercury.

And I remember a young, unsuspecting woman who became severely infected after an abortion on Route 29 here, from a veterinarian's assistant who borrowed equipment from the boss.

I also remember several women who became infected after a local businessman had taken them into the Shenandoah Valley of Virginia to a so-called "retired gynecologist" who in reality was a retired railroad engineer who did abortions on the kitchen table.

Most of all, I remember a beautiful 12 year-old girl who was brought by her step-father, who had previously tried the day before to use a turpentine douche to bring about an abortion.

As it has been already mentioned, desperate women have tried to have abortions for unwanted pregnancies, even though they knew it was illegal, against their religion or the feelings of their society, and in years gone by, even though there was a high percentage chance of them losing their lives.

Whether legal or illegal, abortions have been searched for and carried out for 5,000 years. We just heard the recent tragic story from Romania of increased maternal mortality, increased infections, increased illegal abortion, and in particular, increased abandoned children when the former leader reinstituted more stringent controls on abortion should be a warning to us to make certain that abortion should be legal.

I don't believe in abortion for contraception and certainly have never advocated them for convenience. I do not believe in abortions for sex selection and have never been approached with such a request. Nor have I found any of my fellow gynecologists with whom I've talked who have. There, however, may be certain genetic diseases transmitted by certain sexes that should not be passed down.

I would like to quote from Dr. Leo Dunn, the chairman of the Obstetrical and Gynecological Department at the Medical College of Virginia. In 1987 Dr. Dunn said, "The entrapment of our youth by unwanted pregnancy is indeed an American tragedy that attributes to many societal ills such as poverty, welfare dependence and child abuse."

We are here because of an invasion and intrusion on our private and personal rights. We are here because of a religious minority trying to impose their ideas, interpretations and wishes on our fellow citizens.

As a Christian, I feel their narrow interpretation would actually be imposing requirements on some persons whose religion may be diametrically opposed to those interpretations.

There are at least 220 different religious sects in this country and portions of the bible have been translated into 1,450 different languages, so the interpretations are many and varied. Most important there are theologians, some Catholics, Baptists, Methodists, Episcopalians, Jewish and even Evangelicals who state that there is nothing specifically mentioned in the bible about abortions.

The safety of abortion has been established. It has been studied statistically more than any other operative procedure by, among others, our Center for Disease Control. It is said to be as safe as an injection of penicillin, 100 times safer than an appendectomy, and at least seven times safer than delivery of the unwanted pregnancy at term.

The psychological impact to the mother and baby—and we must consider this more and more—may be much worse and longer-acting when associated with adoption, single parenting, or shotgun marriages.

A large number of the unplanned and unwanted pregnancies will become our financial responsibility on the welfare rolls.

There is already at least one book and a video cassette for TV on "Self-Abortion." In the book with drawings and diagrams is a statement "get antibiotics from your physician but don't let him know what it is for."

You, Senators, know that there is no need for a law unless it is enforceable, and it must be specific. There are already laws, as in Missouri, stated in the preamble to *Webster*, saying that life begins at conception. And regardless of Senator Humphrey's statement and the instructions of the book at Harvard, the scientific world for the most part realizes that conception is not instantaneous, and that we don't even have a pregnancy until implantation occurs. We frequently don't know which act of intercourse brought about the pregnancy.

The preponderance of scientific evidence speaks to life not beginning at any instantaneous moment, and yet some States will certainly press for laws based on this.

Implantation and then individualization does not really occur until the 14–15th day. Depending on who one reads, 20 to 50 percent of these conceptions don't even make it to implantation.

This law to which we speak will prevent chaos as neighboring States enact differing laws. Where a State outlaws or sets the length of time acceptable to termination, the citizens simply go out-of-State or, even worse, out-of-country.

Thus, individual State laws may make it locally not available, particularly for the poor, and it causes further delay and therefore increases the complication rate and the death rate.

The anti-abortion forces very glibly went around claiming the lowered abortion rate in teenagers when parental notification requirements were enacted in Massachusetts. Later, when the final figures were in, adjacent were analyzed, and it was proven that the reduction was accomplished by the teenager going out-of-State. In the early days of the seventies 43 percent of the abortions were done in Washington and New York where the laws were more liberal. The number of Americans having abortions in England went down with legalization of the procedure in this country.

This bill might prevent much legal and State legislative manipulation.

It is important that the U.S. Senate and House of Representatives accept the responsibility for our country and not "pass the buck" in order to make the State legislators responsible and therefore we end up with many different laws.

At this time, there would appear to be no medical, legal or Biblical reasons not to endorse this legislation.

Thank you.

Senator METZENBAUM. Thank you very much, Dr. Jones.

[Additional copy provided by Dr. Jones follows:]

WHEN
BIRTH CONTROL FAILS

HOW TO ABORT OURSELVES SAFELY

By

SUZANN GAGE

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SPECULUM PRESS/SELF-HEALTH CIRCLE, INC.

Hollywood, California

we have available to us. Women have died from hemorrhaging and infection as a result of incomplete abortions, hemorrhaging from uterine perforations and uterine infections from non-sterile abortions and no access to antibiotics to treat the infection. Oftentimes this happens when we are forced to get our abortions from people who lack skills, equipment and common sense. We can prevent many of these things from happening by using common sense, by having knowledge of our bodies and of the equipment necessary and of sterilizing practices.

7. Women work with all kinds of things that can be used in abortions: Q-tips, tongs, bicycle pumps, etc. Tubing is used for fish tanks too. Hardware stores carry an array of items that could be converted to do abortions. Most nurses and midwives are women. They have access to all kinds of tools and have many valuable skills. Some women have prepared stories so that they would appear to be getting equipment for a different purpose.

COMPARING THE RISKS OF DIFFERENT ABORTION METHODS

Statistics on self-abortion for the most part do not exist because women practicing self-abortion have not wanted to put themselves in legal jeopardy. Most of this information has been passed by word of mouth.

Early suction abortion has been statistically shown by medical authorities to be the safest method of abortion. If an early suction abortion is incomplete it can usually be completed by simply doing it again.

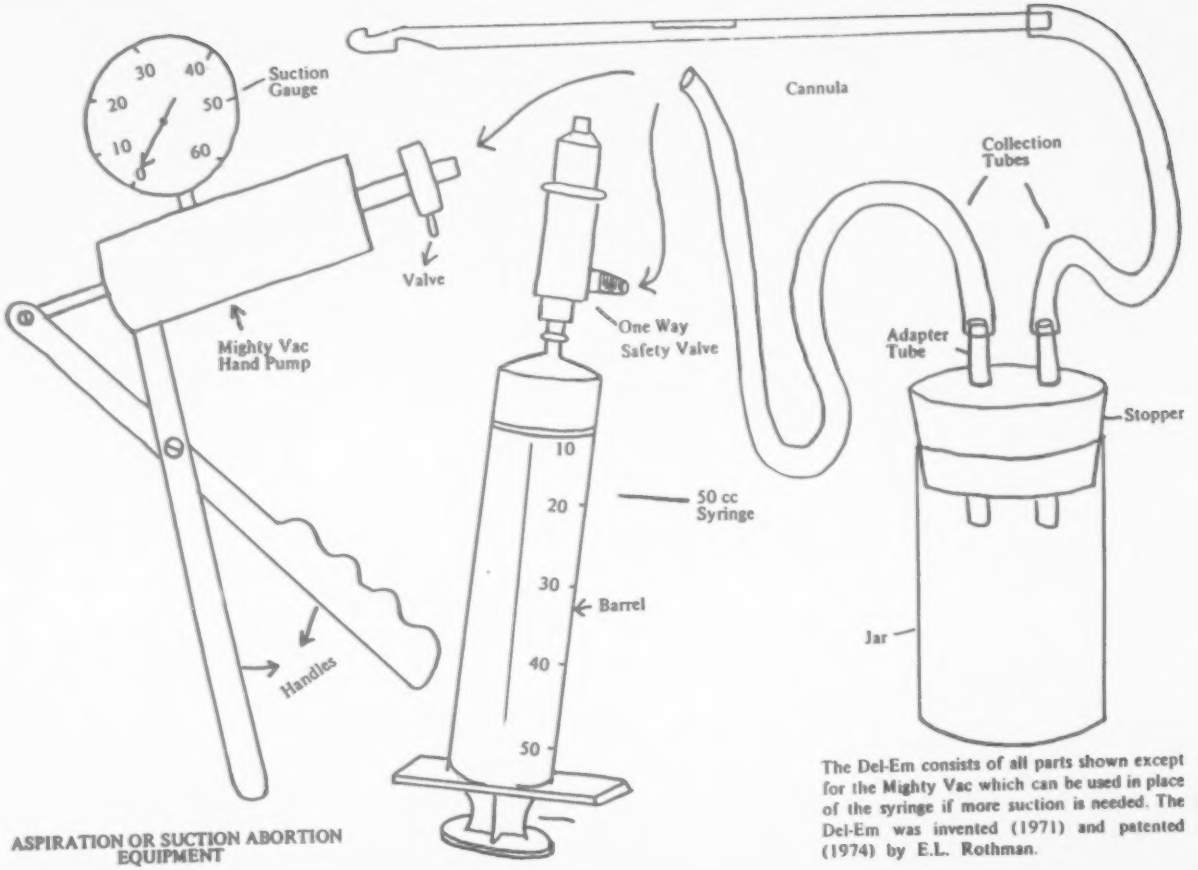
The statistical effectiveness of self-digital, laminaria, direct irritation or self-saline abortion is not known, although later abortion always carries more risk than early abortion. The repeated insertion of anything into the uterus without attempting to sterilize or disinfect it increases the risk of bacteria getting into the uterus which could create an infection. In addition, with self-saline abortion there is the risk of getting air into the uterus which could be fatal. Women have reported that if at first these methods don't appear to be working, persistance will often result in an abortion.

IUD removals may or may not abort a pregnancy. Obviously you cannot repeat this method if it doesn't work because once the IUD is removed, it's removed. An additional method might need to be used to abort or to finish the already started abortion. For example, in early pregnancy an IUD removal might be followed with a suction abortion.

Women have reported that Vitamin C and herbal abortions are most effective very early in pregnancy—even before the missed period. However, taking too much Vitamin C or certain herbs can be harmful.

GETTING A DOCTOR TO DO YOUR ABORTION

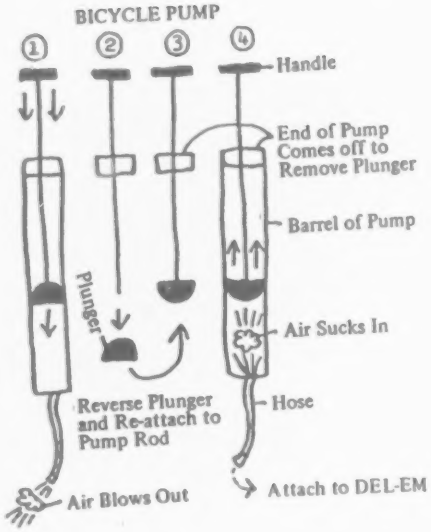
Many women have convinced doctors to do abortions for them by making them believe that they were having a miscarriage. This can be done, for example, by putting the blood and a bit of smashed tissue from calves liver in your vagina to fake a miscarriage. This sort of thing requires a good consistent story and a convincing act. Women who are miscarrying will often have very strong uterine cramps and pains that come and go in waves, a great deal of bleeding, low blood pressure and a slow pulse. They will also feel faint and look pale. Talk to women who have had miscarriages to find out how they felt and what happened to them at the emergency room of their hospital. Some doctors do uterine apsirations or D & C's (dilation and curretage or scraping out the uterus) with no questions asked. Others will make you talk to the police before they abort you. It depends on the doctor 's views on abortion, the laws and the risks he takes legally in aborting you. Because abortion is currently legal in the United States, women don't need to manipulate a physician to do an abortion. However, a woman might have to if she lives in a community where all the physicians are against abortion.

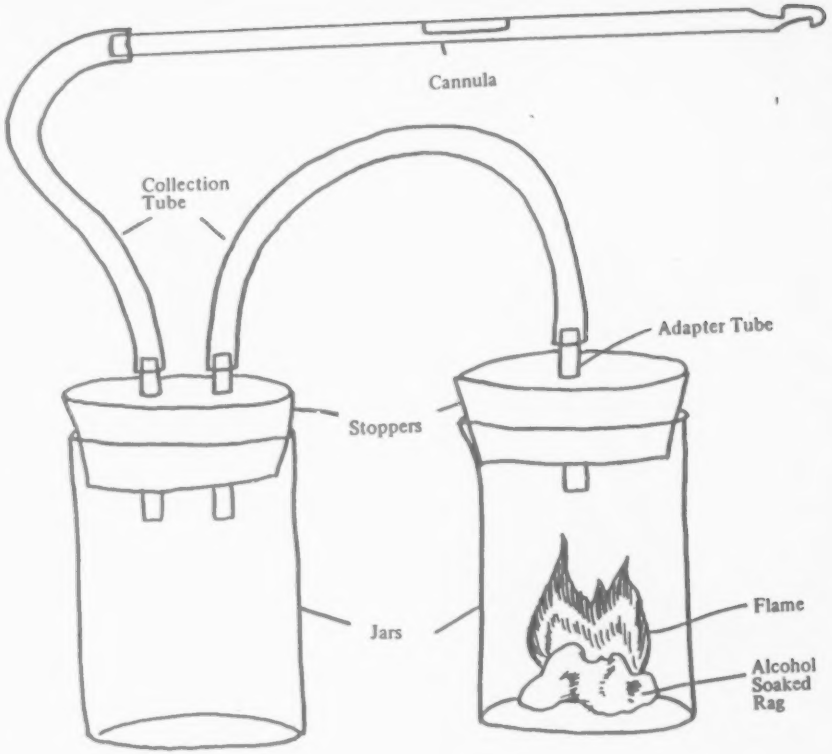


ASPIRATION OR SUCTION ABORTION EQUIPMENT

(Smaller than Life Size)

The Del-Em consists of all parts shown except for the Mighty Vac which can be used in place of the syringe if more suction is needed. The Del-Em was invented (1971) and patented (1974) by E.L. Rothman.



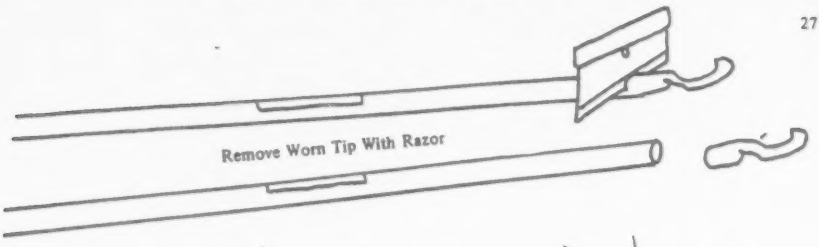


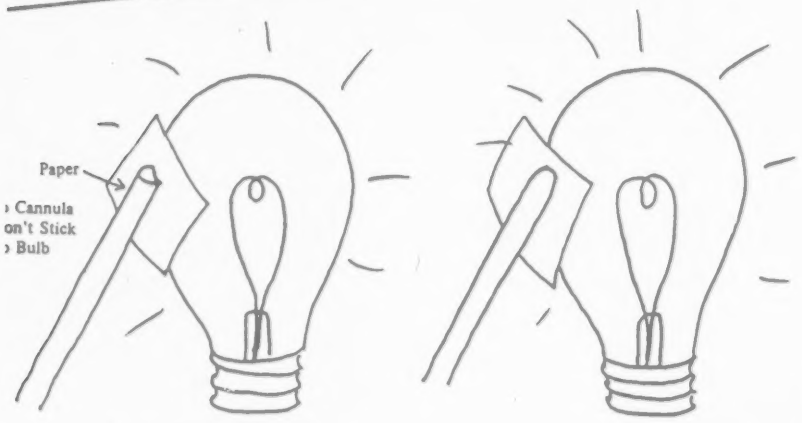
A VARIATION ON THE *DEL-EM*

Smaller Than Life Size

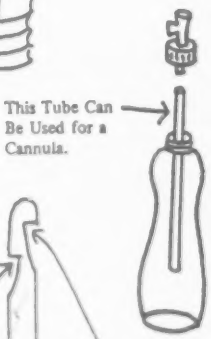
HOW TO MAKE NEW CANNULAS OUT OF OLD ONES

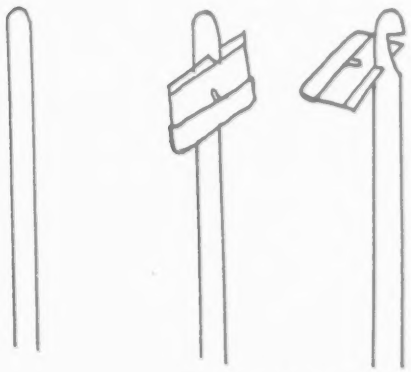
27





Rub Tip Against Hot Light Bulb to Melt End Closed. Make Sure Tip Is Blunt and Smooth.





Carefully Cut Openings as Shown.

Check Tip for Weak Spots

Senator METZENBAUM. We now look forward to hearing from Dr. Gerstley.

Dr. GERSTLEY. Senator Metzenbaum and members of the committee, I am deeply appreciative for the opportunity to come and share my experiences of 37 years in the field of obstetrics and gynecology. I am sorry that because of time limitations I can only sketch the points I need to make.

I was a chief at the Old Philadelphia General Hospital, the large municipal hospital, from 1958 to 1967. During that time, the entire fourth floor of the gynecology, some 32 to 48 beds, were reserved for the very sick, representing only the botched criminal abortions among the poor in Philadelphia. We admitted between six and eight such patients daily, where we saw many very ill losing their entire pelvic organs surgically in attempts to save their lives, in spite of which quite a few died.

Those who had some money or insurance went to the other hospitals in the Philadelphia area, where they were admitted usually under a face-saving diagnosis different from "abortion" to virtually every hospital in the area on a daily basis.

I have brought with me for your inspection photos of three patients I took care of and had the opportunity to photograph.

One picture is of a uterus I had to remove from a 22 year-old woman under local anesthesia in a vain attempt to save her life. She came in in complete septic shock—no blood pressure, no pulse. Several hours of intensive work failed to improve her, and I had to remove the source of the toxins as a final attempt to save her life. I could not give her anesthesia because in those days, they required a blood pressure and pulse to monitor anesthesia, and there was none in this woman. So I had to do this under local anesthesia.

Walking back with her on the stretcher to her ward, she held my hand, mentally lucid—toxic shock patients frequently remain mentally lucid until the end—she held my hand and said, "Doctor, I'm dying." There was nothing I could do, and she never made her bed. She died on that stretcher. I don't want to ever see that again.

The next are of kidneys of a woman who died after attempting to abort herself by a lysol douche that gave her a toxic peritonitis.

The final picture is of the vagina of a woman with potassium permanganate burns, another one in an attempt to abort herself. The potassium permanganate tablets put in acted like a red-hot poker, frequently caused bleeding that was almost impossible to control, or perforated into the bladder or the rectum and created quite a nasty fistula.

To further indicate that the number of criminal abortions were about one million per year before legalization—legalization has done very little to increase the number; they were being done—I made this graph, which shows the number of abortions done in the United States in the year before *Roe v. Wade* through the present. You will see that the two lines run perfectly parallel. There has been no decrease in the number of live births due to the increasing number of abortions, and I represent that nobody goes out and gets pregnant for the kicks of having an abortion.

It is obvious that legalization has only made abortion safer. There are two women who will go to the ends of the earth to get

help if they can afford it—the woman who wishes to get pregnant and cannot, and the woman who finds herself intolerably pregnant.

I remind you also that no one uses it as birth control. That argument keeps coming up, and it is fallacious. It is far too expensive a method—physically, emotionally and financially—and also, about 20–25 percent of all abortions done are done for the failures of the proper use of accepted methods of contraception.

Failing to provide abortion services for the poor helps to keep them mired in poverty, and parenthetically, increases the cost of other welfare services several hundred to over 1,000 percent.

Requiring consents of spouses or parents assumes normal family relationships which are present, fortunately, in the great majority of cases and present no problem there. But where there are disrupted or emotionally ill families, holding the spouse or child hostage to consent can only wreak havoc.

Regardless of how one feels about abortion, no one attempts to force abortion on those who feel it wrong, and I don't think that those who feel it wrong should try to force their views on people who feel different through law.

Abortions have been done as long as there has been recorded history, are being done, and will continue to be done. The only question is who will be allowed to do them—trained physicians, under safe facilities, or——

Thank you.

Senator METZENBAUM. Thank you very much.

Ms. Richard, do you have a statement to make in addition to the movie that you wish to present?

Ms. RICHARD. Mr. Chairman, I do have a video that I can cut down to 5 or 6 minutes, and then with my testimony, I could in 2 minutes. I would like to extend an extra 2 minutes, seeing we have heard from six witnesses on the opposite and me being the only pro-life witness, I would like to ask permission to extend my testimony.

Senator METZENBAUM. You want to make an oral statement for 2 minutes, and then you want 5 or 6 minutes for the video; is that it?

Ms. RICHARD. If that would be okay.

Senator HATCH. What might be good is to show the video and make your statement as you are showing what happens on the video.

Ms. RICHARD. Well, the voice-over is already on, and I wasn't prepared to do that.

Senator HATCH. Oh, OK, that's fine.

Senator METZENBAUM. As long as you keep it to 5 or 6 minutes, and we will give you the extra 2 minutes to make an oral statement.

Have you got it foreshortened at this point, or will it take longer than 5 to 6 minutes?

Ms. RICHARD. The actual video is 8 minutes, but I am planning on just showing the first-trimester babies because of time, so I'll cut it short. I will just have an introductory statement before I get up there, and then I'd like to present my testimony, which would take 2 minutes.

Senator METZENBAUM. How long is your introductory statement?

Ms. RICHARD. If you could allow me 7 to 8 minutes, I could do my whole presentation.

Senator METZENBAUM. Please proceed.

Ms. RICHARD. Thank you.

My name is Shari Richard, and I am a registered ultrasound technician. I have been registered in obstetrics and gynecology for 10 years.

When I first got into this field, we did not know what we knew about the unborn now. With real-time ultrasound imaging, we were able to see a motion picture of the baby, and we literally learned for the first time that this baby is mobile in the womb all the time during its waking hours in that first trimester period.

Just recently in the last 2 years, trans-vaginal sonography has come, and now we are able to see information about the embryo one to 2 weeks earlier than we were able to 2 years ago. I will show you the fetal heartbeat at just 4 weeks, and I will go into that in more detail later.

I found out that most women and most people were really ignorant about prenatal development. Many women are unaware that that baby is totally mobile at 8 weeks conception.

So I put together a video which you will see portions of, called "Ultrasound: A Window to the Womb", where I used state-of-the-art ultrasound imaging and show fetal development.

Personally, it is very rewarding for me to watch those little babies. They seem to have unique personalities. I watch them as they suck their thumbs, jump—at 10 weeks, they are jumping around—and I get attached, I can't help it. I see these babies every day.

Many women have changed their minds about terminating their pregnancies when they view that little baby on the screen. They are told it is a glob of tissue, a product of conception. In fact, I have been personally told to turn the monitor when women are considering to abort their pregnancy because it just might influence her choice.

I believe as a free society that believes in the right of choice, then they also have the right to be informed in order to make that choice.

I believe it is very easy for this world and these people here to deny the existence of what we can't see, feel and hear. And if there was a window placed upon the abdomen of every pregnant woman, and you all could view what I see on an everyday basis, I really don't believe I would have to be here today defending that unborn.

But I am going to show this to you. I will let myself talk on the video.

[Videotape shown.]

Senator METZENBAUM. How much more do you have? Your time has run out.

Ms. RICHARD. I appreciate the extra time. I just want to close by saying that I personally cannot help but be attached because I do see these babies perform regular activities inside the womb. It is very distressing to me when I get a patient—just last week I was called out of lunch and told that I had to do a stat ultrasound for fetal age to make sure she wasn't too far along. They wanted to do an abortion on her, and it had to be done quickly because she was

at the borderline. This specific baby was 14 weeks old. And I literally had to sit there and get kidneys, bladder, stomach, spine for the physician, so he could read it all. It just seemed too ironic—as I am sitting there, doing all these measurements and looking for all these organs, and this baby literally jumped at me all through that time. In fact, the mother of the daughter just watched and watched. And after it was over, and the daughter went to the bathroom, the mother said, "I feel so sorry for you." And I said, "Why?"

"How can you watch these babies, knowing that they are going to be killed?"

And I looked at her, and I said, "It is very hard, but I feel sorry for you, because this is your grand-daughter or grandson."

She said, "Well, I'm going to deny it, because I have no choice but to do this, and I'm going to close my mind to it. But I feel sorry for you because you've got to see the reality every day."

So I am here to just show you what is going on in the womb.

Thanks.

[The prepared statement of Ms. Richard (with attachments) follows:]

PREPARED STATEMENT OF SHARLEEN RICHARD

Mr. Chairman, my name is Sharleen (Shari) Richard. I am a registered Radiologic Technologist (R.T.) and a Registered Diagnostic Medical Sonographer (R.D.M.S.) in Obstetrics/Gynecology and Abdominal Sonography. I received my ultrasound training at Bowman Gray School of Ultrasound in Winston-Salem, North Carolina in January 1981. I became registered in March 1983. Additional education and experience is listed on my resume.

Major advancements in ultrasonography in just the last ten years has allowed us to learn more about the unborn child at an earlier age. In the late 1970s Realtime Ultrasound was developed enabling us to see moving images of the unborn baby. Watching the ultrasound screen, we quickly became aware that the child is virtually always in motion during its waking period.

During the earlier years of Realtime Sonography, the resolution was very poor and even a trained eye had problems detecting normal anatomy. During the mid 1980s, the resolution continued to improve, and we were able to identify the heart beating at five and a half weeks from conception and watch the baby move vigorously within the womb at seven weeks from conception.

In the last few years, trans-vaginal sonography has been discovered. A vaginal transducer is introduced through the vaginal canal, and due to the higher frequency of the transducer and because we are able to get within 1-2 centimeters of the embryo, the resolution is superb. Trans-vaginal sonography has allowed us to detect information on the embryo one to two weeks

earlier than with the conventional transabdominal procedure through a full urinary bladder.

There are two methods of dating the unborn baby: Menstrual age and conception age. The gestational age, or conception age, is the time of conception, which occurs soon after ovulation. Because most women do not know the exact day they ovulate, the first day of the last menstrual cycle, or menstrual age, has been adopted by the medical professionals as a standard. I will refer to both gestational age and menstrual age in my testimony.

MA = menstrual age

GA = gestational age

(1) 4 weeks, 3 days (MA) or 2 weeks, 3 days (GA): the gestational sac can be identified in the endometrium.

(2) 6 weeks (MA) or 4 weeks (GA): the fetal pole and the heartbeat can be detected.

(3) 7 weeks (MA) or 5 weeks (GA): the head and body could be identified and a crown rump measurement can be obtained.

(4) 8 weeks (MA) or 6 weeks (GA): the head, with a single ventricle, and the limb buds can be seen, and it is possible to see the blood flowing through the umbilical cord. Almost <u>half</u> of all the abortions performed in the United States are performed <u>after</u> the eight week point (MA), which is six weeks gestational age, according to statistics published by the Federal Centers for Disease Control.

(5) 9 weeks (MA) 7 weeks (GA): structures of the mid brain first appear; the partition of the falx and choroid plexus. At this time, movement can be observed.

(6) 10 weeks (MA) 8 weeks (GA): individual fingers and toes can be identified. The unborn measures one inch and all organs are now present but need to develop and grow.

(7) 12 weeks (MA) 10 weeks (GA): vigorous activity can be seen as the baby utilizes the whole uterine sac. The baby turns, jumps, waves its arms, and sucks its arms. Because of the fluid and large amount of space in the womb, the 10-week-old baby is more active than a term or newborn baby.

(Information taken from Contemporary OB/GYN, April 1988 edition, "High Frequency Trans Vaginal Sonography: New Diagnostic Boon", by Ilan E. Timor Tritsch, M.D.)

Second trimester (12-28 weeks)

By the beginning of the second trimester, the unborn can urinate, breathe, and swallow the amniotic fluid. Ultrasound images reveal the babies opening their mouth, sucking thumbs, sticking tongues out, and yawning.

It is a rewarding experience as a sonographer to observe and introduce the babies to the parents for the first time. There is a natural bonding that immediately develops when the mother and father are able to witness this life within the womb. In fact, many women have changed their minds about terminating their pregnancies after they view their babies totally formed and moving vigorously within the womb as early as eight weeks from conception.

I have been instructed by doctors and hospital personnel to turn the monitor away from the mother's view when she is considering an abortion because "it might just influence her choice." An article published in the OB/GYN News from February 1986 quotes Dr. Sally Faith Dorfman speaking at the annual meeting of the American Public Health Association: "Seeing a blown-up, moving image of the embryo she is carrying can be distressing to a woman who is about to undergo an abortion." She stressed that the screen should be turned away from the patient. "Staff members also may be affected by sonographic images and may need opportunities for venting their feelings and reconfirming their priorities," Dr. Dorfman said.

As a society that says they believe in "freedom of choice," don't we also have the right to be informed in order to make our choices? Abortion is the only surgical procedure protected by law that does not require the physician to divulge all the pertinent information of that procedure. It has been my experience that many women are discovering these facts after having an abortion and are experiencing guilt, depression, and anger, because they were not informed. The unborn child was referred to as a glob of tissue, product of conception, or "two tablespoons of matter."

I believe women should also be informed of complications and risks in future pregnancies. Many women are referred to me in the emergency room following complications from an abortion. It is not uncommon for me to find retained products of conception left behind inducing severe infection. One such case was the

remains of a sixteen-week old head, left behind from a suction abortion.

I am a victim of two abortions and suffered from severe infection and bleeding due to retained products of conception left inside. I did not feel any guilt afterward because I was told it "was not a baby." I continued to be very careless with my birth control because I always knew I could have an abortion. It is not uncommon for my patients to testify of 3-5 abortions, and many use it as birth control. It wasn't until I went to ultrasound school and saw that little 8-week old baby totally formed and moving around that I was aware of what I had done. I knew for the first time I had destroyed two human lives, and that's when the guilt came. I went into severe depression, guilt, and anger believing I could never conceive again. It wasn't until I forgave myself, I asked my unborn babies to forgive me, and I asked My God to forgive me that the guilt was released. Through that prayer, I was able to experience peace within myself and conceived the first of my three children that month.

Our society has a way of denying what we cannot see, feel, or hear. But I believe if every pregnant woman had a window placed upon her abdomen and the world could view these babies developing and growing, as I do through ultrasound, I don't think that I would need to be here defending the unborn child today.

I believe as a society based on "freedom of choice" we should also be given all the information to make a choice.

Ob.Gyn. News 42 February 15-28, 1986

Warns of Negative Psychological Impact of Sonography in Abortion

International Medical News Service

WASHINGTON — Sonography can make induced abortion safer, but care must be taken so that its psychological impact is not negative, Dr. Sally Faith Dorfman said at the annual meeting of the American Public Health Association.

The most obvious use of sonography in abortion is in helping to establish the age of the fetus. Estimation of fetal age is essential in determining the legality of abortion in certain cases and in helping physicians decide on the appropriate abortion procedure to use and the type of facility in which it should take place.

Enhancing Accuracy

Inaccurate estimates are associated with increased maternal mortality and morbidity, said Dr. Dorfman, of Albert Einstein College of Medicine, New York.

Although estimates of fetal age based on sonography are only approximate, they are generally more accurate than are those based on physical examination or recollection by the patient of the date of her last menstrual period, Dr. Dorfman said.

To enhance accuracy, a variety of sonographic measurements may be made and compared, she noted.

Because of the advantages offered by sonography, an obstetric advisory subcommittee, which Dr. Dorfman chaired, has recommended to the New York City Department of Health that the procedure be used in all abortion cases beyond 12 menstrual weeks.

The subcommittee also recommended use of sonography in earlier cases if a discrepancy exists between menstrual dates and uterine size or if there are other questionable findings.

These recommendations were incorporated into guidelines issued by the New York City Department of Health in March 1985.

The subcommittee was aware that the sonography recommendation might increase costs and cause delays but felt that the benefits of the procedure generally outweigh these drawbacks, Dr. Dorfman noted during her presentation at the public health meeting in Washington.

Although delaying an abortion is almost always undesirable and may at times have serious consequences (such as necessitating a more complex type of procedure), the subcommittee believes that if clients and clinic personnel remain vigilant, significant delay can be avoided.

Besides its use in ascertaining fetal age, sonography can be very helpful during actual abortion procedures, both as a teaching tool and as a means of enhancing safety.

But sonography in connection with induced abortion may have psychological hazards. Seeing a blown-up, moving image of the embryo she is carrying can be distressing to a woman who is about to undergo an abortion, Dr. Dorfman noted.

She stressed that the screen should be turned away from the patient.

Staff members also may be affected by sonographic images and may need opportunities for venting their feelings and reconfirming their priorities, Dr. Dorfman said.

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

September 29, 1989/Vol. 38/No. 38

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Current Trends

Abortion Surveillance: Preliminary Analysis – United States, 1986 and 1987

In 1986 and 1987, 1,328,112 and 1,353,671 legal abortions, respectively, were reported to CDC from the 50 states and the District of Columbia (Table 1). From 1985 to 1986, the number of legal abortions decreased <1%; from 1986 to 1987, the number increased by 1.9%.

In 1986, the national abortion ratio was 354.2 legal abortions per 1000 live births (Table 1); in 1987, the ratio was 356.1. The national abortion rate (number of legal abortions per 1000 women 15–44 years of age) was 23 for 1986 and 24 for 1987. In both years, 92% of women who had legal abortions were residents of the state in which the procedure was performed (Table 1).

Women obtaining legal abortions in 1986 and 1987 were predominantly <25 years of age, white, and unmarried and had had no live births (Table 1). Curettage (suction and sharp) remained the primary method of abortion and accounted for 97% of all legal abortion procedures in 1986 and 1987, respectively. In both years, as in previous years, slightly more than half the legal abortions were performed in the first 8 weeks of gestation, and nearly 90%, in the first 12 weeks (Table 1).

Reported by: Pregnancy Epidemiology Br and Research and Statistics Br, Div of Reproductive Health, Center for Chronic Disease Prevention and Health Promotion, CDC.

Abortion – Continued

TABLE 1. Characteristics of women who obtained legal abortions – United States, selected years, 1972–1987

Characteristic	1972	1976	1980	1984	1985	1986	1987
Reported no. legal abortions	586,760	988,267	1,297,606	1,333,521	1,328,570	1,328,112	1,353,671
Abortion ratio[a]	180.1	312.0	359.2	364.1	353.8	354.2	356.1
Abortion rate[b]	13	21	25	24	24	23	24
	Percentage distribution[c]						
Residence							
Abortion in-state	56.2	90.0	92.6	92.0	92.4	92.3	92.0
Abortion out-of-state	43.8	10.0	7.4	8.0	7.6	7.7	8.0
Age (yrs)							
≤19	32.6	32.1	29.2	26.4	26.3	25.3	25.8
20–24	32.5	33.3	35.5	35.3	34.7	34.0	33.4
≥25	34.9	34.6	35.3	38.3	39.0	40.7	40.8
Race							
White	77.0	66.6	69.9	67.4	66.6	67.0	66.4
Black and other	23.0	33.4	30.1	32.6	33.4	33.0	33.6
Marital status							
Married	29.7	24.6	23.1	20.5	19.3	23.5	27.2
Unmarried	70.3	75.4	76.9	79.5	80.7	76.5	72.8
No. live births[d]							
0	49.4	47.7	58.4	57.0	56.3	55.1	53.6
1	18.2	20.7	19.5	20.9	21.6	22.1	22.8
2	13.3	15.4	13.7	14.4	14.5	14.9	15.5
3	8.7	8.3	5.3	5.1	5.1	5.3	5.5
≥4	10.4	7.9	3.2	2.6	2.5	2.6	2.6
Type of procedure							
Curettage	88.6	92.8	95.5	96.8	97.5	97.0	97.2
Suction	65.2	82.6	89.8	93.1	94.6	94.5	93.3
Sharp	23.4	10.2	5.7	3.7	2.9	2.5	3.7
Intrauterine instillation	10.4	6.0	3.1	1.9	1.7	1.4	1.3
Hysterotomy/ hysterectomy	0.6	0.2	0.1	0.0**	0.0**	0.0**	0.0**
Other	0.5	0.9	1.3	1.3	0.8	1.6	1.5
Gestation (wks)							
≤8	34.0	47.0	51.7	50.5	50.3	51.0	50.4
9–10	30.7	28.0	26.2	26.4	26.6	25.8	26.0
11–12	17.5	14.4	12.2	12.6	12.5	12.2	12.4
13–15	8.4	4.5	5.7	5.8	5.9	6.1	6.2
16–20	8.2	5.1	3.9	3.9	3.9	4.1	4.2
≥21	1.3	0.9	0.9	0.8	0.8	0.8	0.8

[a]Number of abortions per 1000 live births.
[b]Number of abortions per 1000 women 15–44 years of age.
[c]Excludes unknown values. Since the number of states reporting each characteristic varies from year to year, temporal comparisons should be made with caution.
[d]For 1972 and 1976, data indicate number of living children.
**<0.05%.

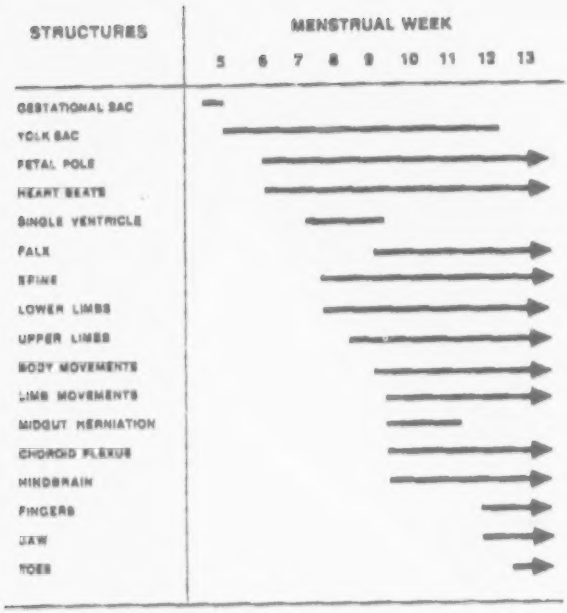

Fig. 9. Sequential appearance of embryonic structures/functions.

September 1988
American Journal Obstetrics/Gynecology
Timor-Tritsch, Farine, and Rosen

Cincinnati Enquirer June 26, 1989

Child from Roe vs. Wade located; she is 19 and staunchly anti-abortion

BY ROCHELLE SHARPE
Gannett News Service

LOS ANGELES — The child at the center of the *Roe vs. Wade* case was recently located and told that her conception led to the Supreme Court's landmark abortion decision, according to an adoption search consultant.

The child, now 19, is presumably the biological daughter of Norma McCorvey, the Texas woman who used the pseudonym Jane Roe to challenge her state's restrictive abortion laws.

A college student, she lives in a Seattle suburb with her adoptive mother and is staunchly anti-abortion, according to Toby Hanft, the adoption search consultant who met the child and told her about McCorvey.

"I'm sure it's her," said Hanft, who runs a business in San Francisco that reunites adoptees with their biological parents. "The stats — her date of birth, weight, time of birth — are all the same."

She was mortified

The child was mortified when she learned the identity of her biological mother, Hanft said. At first, though, "she didn't know who Jane Roe was."

Sitting in a hotel restaurant with the young woman, her adoptive mother, her boyfriend and her best friend, Hanft said she explained the *Roe vs. Wade* case, then handed the girl a *People* magazine story about McCorvey.

"She looked at it, and it sunk in," Hanft said. "She threw it down and ran out of the room."

"It was horrible," Hanft said. "Imagine your mother not wanting you so much that she went to the Supreme Court to get rid of you."

The young woman was located by the *National Enquirer*, which announced in its June 20 edition that it had found McCorvey's daughter.

Wanted to find child

McCorvey said earlier in the year that she wanted to find the child she had relinquished for adoption. Although she originally sought an abortion, she never got one because her lawsuit challenging the Texas law took three years to make it to the Supreme Court.

Neither McCorvey nor her lawyer would say whether the *National Enquirer* had found her child, complaining, instead, that the article was filled with inaccuracies. They refused to say what was untrue.

"I don't wish to comment on the story because it is so full of falsehoods," McCorvey said. "I still want to find my child I gave up for adoption. If I do find her, it will be in a private place and it will in no way be associated with the *National Enquirer*.

"It's such a sensitive issue. Maybe some damage has been done to the woman who may or may not be my child. I don't want to hurt her or my child in any way."

Gloria Allred, a California attorney who has befriended McCorvey, said: "She's never had a blood test. There is no conclusive evidence."

Hanft said she got involved in the case after the *National Enquirer* asked her to serve as an intermediary in the reunion. Although she said she dislikes the newspaper and never reads it, she decided to help because she thought she could cushion the shock.

"I did it because it was a choice — either they would show up at her door with a photographer and blow her away or I could explain it to her," she said.

Before she went to Seattle, Hanft said she talked at length with McCorvey, sometimes six or seven times a day.

Alive and well

McCorvey told Hanft to tell her daughter she was glad she had not had the abortion and was happy to know the girl was alive and well, the adoption consultant said. Although she said she was still pro-choice, she promised to stop participating in abortion rights marches, Hanft said, and instead work for liberalizing adoption laws.

Hanft said she has yet to talk to McCorvey about the restaurant meeting because the activist hasn't returned her phone call.

Abortion: The Romanian Example (Cont'd.)

A letter from Kenneth Joswiak and Linda Mason [letters, Jan. 16] quoted me as stating that the organization which I head, the National Right to Life Committee, "is opposed to birth control as well as abortion." I never made any such statement. Neither I nor NRLC has ever advocated restrictions on contraception. Since its formation in 1973, NRLC has consistently defended the right to life of human beings who are threatened by abortion, infanticide and euthanasia. We have just as consistently expressed complete neutrality regarding non-abortive birth control.

It is also false to assert that the pro-life movement wishes to impose policies like those of the late Romanian dictator Ceausescu. Ceausescu had no concern with the welfare of children, born or unborn. He banned not only abortion but also all methods of contraception, and even adoption of Romanian orphans by foreigners, purely as methods of "reverse population control." Even the anti-abortion component had nothing to do with the intrinsic right to life of the unborn child, as demonstrated by the provision permitting abortion for women who had four children.

In Romania, women who procured illegal abortions were themselves subject to criminal penalties, and were therefore afraid to seek medical care for abortion-related complications. In contrast, women were not penalized under the strong anti-abortion laws in effect in the United States prior to *Roe v. Wade*, and NRLC opposes penalizing women in the future. In the United States after the advent of antibiotics and transfusions there were few abortion-related deaths—39 nationwide in 1972, the year before *Roe*, according to the Center for Disease Control.

There are now 1.6 million legal abortions annually—more than twice as many as the year *Roe v. Wade* was decided—and half of the women obtaining legal abortions admit that neither they nor their partner was using any method to prevent conception. Over 40 percent say that they have obtained at least one previous abortion. In the United States, legal abortion is being employed as a method of birth control. It is perfectly possible to again craft laws that would shut down abortion mills, and save hundreds of thousands of human lives each year, without creating a Romania.

JOHN C. WILLKE
President, National Right to Life Committee, Inc.
Washington

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CEAUSESCU

His anti-abortion stand was not based on belief of life's sanctity

The end of Nicolae Ceausescu's reign in Romania brought us new details of the ways one man oppressed an entire nation. In a front page story on Jan. 5, the *Washington Post* chose to focus on Ceausescu's restrictive abortion policy and the new government's decision to legalize abortion.

Such coverage casts the totalitarian Ceausescu as an ally of the pro-life movement, and associates "f[illegible]om of choice" on abortion with trends toward [illegible]tion and democracy generally. A closer [illegible] reveals that Ceausescu was as different f[illegible] a pro-lifer as night and day.

One di[illegible]ence lies in the fact that Ceausescu placed enormous pressure on women to have abortions even as he banned abortion. Women were monitored to ensure that they were not taking steps to prevent pregnancy, even by methods morally acceptable to the Catholic Church, so abortion became a first-resort method of birth control.

EVEN AS HE TRIED to ensure that every Romanian woman had at least five children, his draconian economic policies deprived women of the food, clothing, shelter and fuel needed to care for their families; children whose parents could not cope were warehoused in state institutions and forgotten.

Clearly his policies were not designed to prevent abortion or promote other alternatives as such; in fact he allowed abortion for women who had produced their "quota" of children.

Second, he did something American abortion laws have never done and will never do. He imposed harsh criminal penalties on women for undergoing abortions. Women with complications from illegal abortions avoided medical treatment out of fear of a jail sentence, and many died.

This phenomenon is one reason major American pro-life groups reject the idea of penalties for the woman involved. Pro-life laws should help women receive immediate care for complications and allow them to testify against dangerous "back-alley" abortionists so they can be put out of business.

THIRD AND MOST importantly, Ceausescu's motives were diametrically opposed to those of the Catholic Church and other pro-life advocates.

He cared nothing for individual freedom or individual life, born or unborn. Women were treated as breeding machines to raise the population and hence the power of the Romanian state; children born under the policy were statistics, for their number was monitored but their well-being ignored.

On all points the Church stands for the opposite approach. While urging spouses not to use methods of family planning that erode the dignity of human procreation, the Church teaches that they have "the inalienable right to found a family and to decide on the spacing of births and the number of children to be born." "Public authorities" who infringe on this right commit a "grave offense against human dignity and justice" (Vatican *Charter of the Rights of the Family*, 1983, Article 3).

THUS THE CHURCH rejects the totalitarian "five-children-per-family" policy of Ceausescu as well as the coercive "one-child-per family" policy of Communist China. Ironically, American "pro-choice" leaders have endorsed the latter policy of coerced abortion, showing themselves to be more "pro-abortion" than "pro-choice."

In the Catholic view, freedom to plan one's family does not extend to the killing of newly conceived family members. But mother and child must be equally protected: "Children, both before and after birth, have the right to special protection and assistance, as do their mothers during pregnancy and for a reasonable period after childbirth" (Id., Article 4).

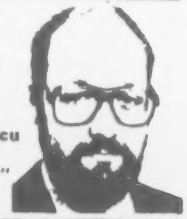
The *Post* and others also missed the significance of Romania's new permissive abortion law. This is not an opening to Western freedom, but a return to the Communist "party line" of the Soviet Union, which in 1920 became the first Western nation to legalize elective abortion.

There is a final irony. In the Philippines, the move from Marcos' dictatorship to Aquino's democracy has meant a new Constitution ensuring protection for unborn children as persons.

IN POLAND, the erosion of Communist rule has meant a freedom for non-Communist Catholics to call for better protection of the unborn. In Romania itself, the pope's envoy has said that a Catholic Church suppressed under Ceausescu is now preparing to contribute to the "social life" as well as religious life of this nation.

In Romania as elsewhere, authentic religious and political freedom may lead to new policies that respect life and reject the illusive "freedom" to abort.

Richard Doerflinger



"Such coverage casts the totalitarian Ceausescu as an ally of the pro-life movement ... A closer look reveals that Ceausescu was as different from a pro-lifer as night and day."

(Richard Doerflinger is associate director for policy development at the Office for Pro-Life Activities of the National Conference of Catholic B[illegible]ops.)

Ob Gyn. News 42 February 15-28, 1986

Warns of Negative Psychological Impact of Sonography in Abortion

International Medical News Service

WASHINGTON — Sonography can make induced abortion safer, but care must be taken so that its psychological impact is not negative, Dr. Sally Faith Dorfman said at the annual meeting of the American Public Health Association.

The most obvious use of sonography in abortion is in helping to establish the age of the fetus. Estimation of fetal age is essential in determining the legality of abortion in certain cases and in helping physicians decide on the appropriate abortion procedure to use and the type of facility in which it should take place.

Enhancing Accuracy

Inaccurate estimates are associated with increased maternal mortality and morbidity, said Dr. Dorfman, of Albert Einstein College of Medicine, New York.

Although estimates of fetal age based on sonography are only approximate, they are generally more accurate than are those based on physical examination or recollection by the patient of the date of her last menstrual period, Dr. Dorfman said.

To enhance accuracy, a variety of sonographic measurements may be made and compared, she noted.

Because of the advantages offered by sonography, an obstetric advisory subcommittee, which Dr. Dorfman chaired, has recommended to the New York City Department of Health that the procedure be used in all abortion cases beyond 12 menstrual weeks.

The subcommittee also recommended use of sonography in earlier cases if a discrepancy exists between menstrual dates and uterine size or if there are other questionable findings.

These recommendations were incorporated into guidelines issued by the New York City Department of Health in March 1985.

The subcommittee was aware that the sonography recommendation might increase costs and cause delays but felt that the benefits of the procedure generally outweigh these drawbacks, Dr. Dorfman noted during her presentation at the public health meeting in Washington.

Although delaying an abortion is almost always undesirable and may at times have serious consequences (such as necessitating a more complex type of procedure), the subcommittee believes that if clients and clinic personnel remain vigilant, significant delay can be avoided.

Besides its use in ascertaining fetal age, sonography can be very helpful during actual abortion procedures, both as a teaching tool and as a means of enhancing safety.

But sonography in connection with induced abortion may have psychological hazards. Seeing a blown-up, moving image of the embryo she is carrying can be distressing to a woman who is about to undergo an abortion, Dr. Dorfman noted.

She stressed that the screen should be turned away from the patient.

Staff members also may be affected by sonographic images and may need opportunities for venting their feelings and reconfirming their priorities, Dr. Dorfman said.

Senator METZENBAUM. We appreciate your concern and the movie. If anybody wants to see it at the conclusion of the hearing, the balance of it, we can turn it on for them.

Both Senator Hatch and I and Senator Coats are under some pressure to be somewhere else at this point.

I wonder, Dr. Jones, or Dr. Gerstley, if either of you would care to comment on the movie and your interpretation or reaction, or anything you'd care to add about it?

Dr. GERSTLEY. I have seen these movies before. They are real, they are fine. They are good for women who want to keep their pregnancy. It is encouraging to them. For women who don't, unfortunately, it presents many attempts to put into a fetus that which is not there.

To say that the brain is fully developed is nonsense. It is a rudimentary brain. There is no evidence that it has any capacity to feel pain. The cortex is in no way developed; if you look at it grossly, it is a smooth little bud, and it has none of the convolutions nor the areas that we have to feel pain. It is an attempt to make a human out of something that is not basically yet fully human in the terms that we understand it.

People constantly say it is a human being. What constitutes a human being? Supposing it has—46 chromosomes is the normal human being—supposing it has 45, 44, 48, or 49? Does that constitute a normal human being?

Unfortunately, you may not like the thought but at that point it represents and obligate parasite. And no woman is required—no person is required—to help anybody or any other person that in any way puts their life in jeopardy.

Senator HATCH. You called it an "obligate parasite"?

Dr. GERSTLEY. It is an obligate parasite. It cannot live on its own. It requires the mother to survive.

Senator HATCH. At that early first trimester stage.

Dr. GERSTLEY. What?

Senator HATCH. When can it live on its own, Doctor?

Dr. GERSTLEY. I would say probably about 24 weeks. Most of those that they say are 20 weeks are those that are based on the weight of the baby. And the weight of the baby—it is how long the loaf has been in the oven, not the size of the loaf, that counts. And most of those babies that are under 24 weeks are usually those of women with some sort of cardiovascular, renal problem, poor nutrition, or something where the weight of the baby is less than its actual gestational age. And very few perinatologists will say that anything under 24 weeks at the present time has any chance of survival; if it does survive, it is usually badly damaged as a so-called human being.

Senator METZENBAUM. Dr. Jones.

Dr. JONES. Senator Hatch, you made a statement earlier, I think, that more babies are being saved, or something to that effect. I think that, as I heard it, when we look at it, there are more babies being saved in the 24 weeks and above. We have not moved the time for viability back earlier than the 23, 24 weeks because the lungs and kidneys are immature. And I think the thing we are dealing with here that is so unfair is much of the response is a reflex response, probably secondary in a lot of the earlier stages to

a vaginal probe. And secondarily, if we go to a neurophysiologist or endocrinologist, they will all say that we don't have a complete neurological system even developed until about 29, 30 weeks, give or take one there. So that as far as feeling and sensation is concerned, this is not generally considered to be acceptable. The rest of it is a reflex action.

If I have a woman at term with a breach, and there is a foot, if I just touch that foot, she pulls it back up—or the baby pulls it back up—very, very similar to what you see here with the movement of a vaginal probe, and this baby arching up.

Dr. GERSTLEY. I might add that an amoeba will retract if touched, too.

Dr. JONES. And we do get electrical waves, neurological types of waves as mentioned in some of the advertisements that are put out by the anti-abortion people. But you can get electrical waves by taking cells off the back of my hand and putting them in a petri dish. But it doesn't become the neurological waves that we can study as electroencephalograms until 29 or 30.

Senator METZENBAUM. Let me ask this. Those who oppose abortion rights often argue that abortion is relied on as a means of birth control because it is too convenient. How do you respond to that argument?

Dr. JONES. Well, I made a statement—I don't believe in abortion as a method of contraception, and I agree with my cohort here that I think it very rarely happens. And I must say that if I get someone who comes in who has had multiple abortions, frequently, that's the one I am most likely to turn down, because if they are going to have an abortion, it has to be a learning experience. But many times these women will do exactly what we have advised them to do—whether it is to use an I.U.D. or use the pills—and they become pregnant.

Now, the word "convenience" that has been so well-utilized by the anti-abortion forces, it really sends me back because I don't think we do them for convenience. It is the determination of what is going on. As someone mentioned earlier, all of these people have a problem or they wouldn't be there. The anxiety of a 13 year-old girl who got involved and did not know what she was doing; the 16 year-old who used contraceptives to the beset of her ability—these are not simply for the matter of convenience. These are needed. And unless you are a woman and in that position, there is no way you can understand the anxiety that goes through these people's minds.

Dr. GERSTLEY. I might add also you get spousal rape that is behind not an infrequent number of these abortions, where the husband comes in and doesn't give the wife a chance to use contraception and forces himself on her, and she finds herself intolerably pregnant.

And one thing I might add finally is that at our hospital we had the president of a Right to Life group come in for a therapeutic abortion, we had a recently honorably-released nun who came in for an abortion, and in Philadelphia at one of the free-standing abortion clinics, there is a group of people who picket that. One of the doctors who works there had three of those women come in, have abortions, and go back out on the picket line.

When you get your ox gored, it becomes a tremendous problem, and the problem is that men don't have that problem.

Senator METZENBAUM. Let me ask you one more question. The statute recently passed in Idaho bars doctors from performing abortions that are used as a means of birth control. Do you believe such a law is enforceable?

Dr. GERSTLEY. I don't think so. Women do not use this as contraception. It is far too expensive, as I said. Physically it is expensive, emotionally it is expensive, financially it is expensive. You could buy years of contraception for the cost of one abortion. I have done abortions now since *Roe v. Wade*, and I never saw anybody who came into my office and used it as a contraceptive. No woman goes out and gets pregnant for the kicks of having an abortion or has intercourse without contraception knowingly or willingly. Twenty or twenty-five percent of these things are for failure of proper use of accepted methods of contraception.

I don't see where it fits in. I never saw one.

Senator METZENBAUM. Do you have any reason to believe, Dr. Jones, that women would simply not seek abortions if abortion were once again illegal?

Dr. JONES. I couldn't quite hear you, Senator.

Senator METZENBAUM. Do you think that women would just not seek abortions if abortion were once again illegal?

Dr. JONES. Senator, you can go back in the history books, and that's just not so.

Senator METZENBAUM. Then I want to ask you, Ms. Richard, do you think that women will simply not seek abortions if abortions were once again made illegal?

Ms. RICHARD. I think we have a society where we are never going to come up with the right answer. I am sure there will be women who are going to seek abortion if it became illegal. But if she wants to put herself to that risk of performing an abortion on herself, or having it done by some quack who doesn't know what he is doing, rather than giving that baby up for adoption or to term, that is her choice that she makes, and I am sure there will be people who will make that choice.

Senator METZENBAUM. Do you think it is right to send her into the back alleys as Ms. Matulus, who went to a doctor who was practically a butcher, with a glass of whiskey in one hand and knife in the other hand, and told her to keep her mouth shut? That is one of the dilemmas that we are faced with here as Senators—is that what we require women to do in this modern day and age?

Ms. RICHARD. You know, you hear today of the rap and the incest, and these hard, hard cases, but we are talking about a major majority of these are not being done for that reason.

Anthony Leventino testified in the House last week. He is an ex-abortionist, and he said out of 1,000 abortions that her performed only two were the result of rape, none of incest, and one for anacephalic.

So you are always bringing up these cases that are so few, and I think maybe we should take those few cases—not to say that I agree with it all—but let's center on those and make abortion maybe acceptable in those extreme cases when the mother's health is at risk, because I have seen those cases, and they are real. But

let's talk about the vast majority that are just being done because it is an unwanted pregnancy.

Senator METZENBAUM. What about Marilyn Mosley? You have heard her testify, the woman who testified this morning. She performed an abortion on herself. She did not want the child. Do you think that that is what we should do? Do you think that that is right in society? And that little child, whether it is a child from rape or incest, has the same indicia that you show on your screen. And what bothers me is how those who advocate the right to life position, a) how do they distinguished between the child that is graded by reason of incest or rape, and b) how do they answer a woman such as Marilyn Mosley, who had to perform her own abortion, or others such as Ms. Matulus, who had to go to really a butcher.

People who are on the opposite of this position I am in, I say to myself I understand the concern for life—I'm a proud grandfather, six little children and couldn't be a prouder grandfather, I am the father of four, and I am concerned about life—but I am also concerned about self-inflicted abortions; I am concerned about the mother's right to say for herself whether she is in a position to bring up that child and wants that child. Ms. Mosley said she has a 19 year-old boy and loves the boy very much, but sometimes people feel they can't afford to bring up the child, that they are in no position to make a home for the child.

The question is don't they have some rights, too, and isn't that what this issue is all about?

Ms. RICHARD. Can I comment on that? I really feel sorry for women who would seek to perform their own abortion or go to a back alley. But you know, all day today, we have heard about the women. We haven't heard a whole lot about these unborn babies. And that is my specialty, that is my technology. I see that in the womb. And I want to hear more about that little "parasite" so-called—which I can't believe that word was even used—and to have him say that that "George" who was jumping around like that was reflex—I can't see how anyone—I mean, a 3 year-old saw this, and he recognized the hand, the arm and the baby moving. And these doctors who are calling these babies, totally mobile in the womb and jumping around—boy, that's a lot of reflex action. I wonder what the stimulus is—what is the stimulus on that that kept that baby moving like that?

Dr. GERSTLEY. Any sort of electrical stimulus that comes along from anywhere. You can't say that that baby is thinking about what it is doing. It has no cortex to do that. You are wishfully thinking. You are reading into it your feelings, not scientific fact.

Ms. RICHARD. What's making it move?

Dr. GERSTLEY. An amoeba moves. Does an amoeba have a brain?

Ms. RICHARD. Well, I want to share with you, just because this is my technology. At 12 weeks we have to do a biparietal measurement to determine fetal age, and at that time we have to recognize certain anatomy in the head, such as the ventricals, thalmus, cortoid plexus. And as the baby develops, all those structures appear the same as they do at term, and we have to identify them.

I am not a neurologist; I am not claiming to be. But all I know is when I do amniocentesis, and that baby accidentally gets poked by

the needle, it jumps. And I know one thing, that the pain receptors are taking place in the thalmus, and that thalmus I have to identify at 12 weeks when I do my biparietal measurement.

Senator METZENBAUM. I am going to have to excuse myself. If Senator Hatch and Senator Coats have additional questions, they may continue.

Senator HATCH. Thank you, Senator. We'll try and end the meeting for you. We all have to leave here in just a few minutes.

But I have to say, Doctors, I think as chairman of the Constitution Subcommittee back in 1982-83, I conducted hearings where we had a number of doctors come in and rebut what both of you have said. So there are differences in the medical profession. And of course, as a former medical malpractice defense lawyer, I spent a lot of time trying to reconcile differing opinions of differing doctors. Now, you two perform abortions; others totally disagree with you.

Ms. Richard, it seems to me, not only disagrees with you, but she came about this the hard way.

Is it true, Ms. Richard, that before you entered into your present profession that you had two abortions yourself; is that right?

Ms. RICHARD. Yes, I did. I had my first abortion in 1974, right after it became legal. I was working in x-ray, and I went up to the doctor, and he said, "It will be quick and easy. You could go back on your lunch hour and then go back to work."

At that time, they used a syringe; it wasn't attached to a suction machine. They didn't have the money to buy this expensive suction machine. So what they did was they took a syringe, and they pulled and they pulled—and I have had three children since, and I cannot compare it to the pain I felt at that time.

I went home and suffered from severe bleeding and fever, only to find products of conception left behind, and they had to do the whole procedure again.

Then, 2 years later, I had another abortion. I was informed it was a glob of tissue, and I was told there would be no future complications to pregnancy when I wanted to have a child. At that time, I did not feel guilt, so I went ahead and got lazy on my birth control, knowing that I could always have an abortion if I made the mistake. I did have my second abortion in 1976.

Senator HATCH. What caused you to change your mind with regard to abortion, since you had had two of them? You apparently had a mind change. Tell me what caused that?

Ms. RICHARD. Well, later on I developed complications, and they wanted to do a hysterectomy on me. I was diagnosed as corio carcinoma. I got a second opinion, and he said, "Shari, there is a good chance you can conceive. Just don't do the hysterectomy."

I tried for 5 years trying to conceive and could not, believing that I had aborted the only two babies that I was ever going to give birth to. And then, when I went into ultrasound and saw that little eight-week baby moving around, I knew for the first time that I had destroyed a human life, and that it wasn't a glob of tissue. And then I was very angry because I was not told all the facts to make my decision and to make my choice. And many women are finding that out.

It wasn't until 1 day that I went to the beach and cried tears that I had never cried before and asked my babies to forgive me,

and I forgave myself, and then most of all I asked my God to forgive me, and the peace was put in me for the first time—and that month, I conceived the first of my three children.

Senator HATCH. Well, I remember the testimony back almost 8 years ago where women came in who had just started an organization called Women Exploited by Abortion. It grew to 10,000 women who had had abortions in 1 year. Most of them had had similar experiences to you. They were led to believe this is not a very serious matter; this is just a glob of tissue, and then they went through the tremendous emotional stress and emotional difficulties afterward, and then they started to doubt that that was the right advice after they had had the abortions, and then became very adamantly against abortion. In fact, some of them are much more anti-abortion today then the average Pro Life person.

Now, I think these sonograms that you have shown us here today are very interesting, and I have had testimony then which rebuts the testimony of Dr. Jones and Dr. Gerstley. I know that you both perform abortions, you both feel deeply about it, you feel you are doing what is right. And, that may be, in the eyes of many people.

But I think what Ms. Richard is telling us is that there are a lot of young women who have abortions who are just told it is not serious; there are no real complications; it doesn't involve a moral decision. They are not given any kind of advice or counsel. They are just counseled to have an abortion and get rid of this problem you have. And, then they later find out that it does involve some moral and ethical considerations, it does involve some physical considerations, it does involve some medical considerations. And, you cannot just toss a fetus off as just getting rid of a problem, or just getting rid of this difficulty that may have confronted your life.

Many, many women that I have met have wound up very seriously emotionally troubled because of what they went through—some haven't, I have to admit that.

But I think your testimony has been very important, and I want to give equal time to the doctors, but do you care to say anything else about their testimony?

Ms. RICHARD. Again, let me collect my thoughts. I've pretty much already commented on that. Like you said, many women do choose abortion not knowing all the information, and then when they do come back and see that baby moving, usually on their second pregnancy when I am doing their sonogram, and they are looking and saying, "Wait a minute—that 8-week baby, that's moving around"—and then they put two-plus-two—"Wait, I had an abortion at 8 weeks."

I really do believe it is going to be a lot easier on people if these medical professionals who are doing abortions share all the details with the patient so that when she makes her decision, she is prepared, and she doesn't find out down the road and becomes angry because she was not told.

Again, I say, if a woman has a right to choose an abortion, then why don't you start telling her all the facts so she can properly choose.

Senator HATCH. What you are saying is that a number of these women have not really had a full right to choose because they

really haven't been informed concerning both sides of this issue. That's what you seem to be saying to me.

Ms. RICHARD. That's right.

Senator HATCH. So this "right of choice" slogan is not just some simple little decision. There are lots of interesting and difficult problems involving for some people religion, morals, ethics, just emotional considerations that in many cases, these young women are not even given a chance to choose among. I think this is not the simple little issue that a lot of people think.

Ms. RICHARD. Senator Hatch, quickly, I just want to say that I have saved over 100 babies by not opening my mouth—by just showing that ultrasound to the mother. So again, it is pretty powerful, and I don't think a lot of women would choose abortion who are choosing because they are not given all the information.

Senator HATCH. So if women saw the ultrasound film that you have put together and in addition were given at least some modicum of information to make the choice, it is your belief that many women would not make the choice for abortion.

Ms. RICHARD. Right.

Senator HATCH. And perhaps we wouldn't have these 1.6 to 2 million abortions in the greatest country in the world every year; is that right?

Ms. RICHARD. Yes, I agree with you.

Dr. JONES. Senator.

Senator HATCH. Yes, Dr. Jones.

Dr. JONES. Senator, I think you have hit upon it in a couple of ways. To me the most important thing is the problem of an unplanned or unwanted pregnancy. Now, once they are pregnant, then we've got real problems, and it doesn't make any difference which way you try to solve the problem. There are a group who feel they have been exploited by abortions——

Senator HATCH. It is a huge group.

Dr. JONES [continuing.] But there is also a group just as large who feel they have had problems with giving their babies up for adoption, who are on the other side.

Senator HATCH. Yes.

Dr. JONES. Now, we have to admit that there are people who have problems with abortion—not many. They would be coming out the ears with the number that you quoted earlier of 23-25 million abortions. And we don't see those. But we do see people with some problems. We see problems in people who get married. We see problems in people——

Senator HATCH. Everybody has problems.

Dr. JONES. That's right. So we have the problems.

I am very fortunate in that about 30 percent of the patients that I get exposed to have already been to what we call a crisis pregnancy center, which does not advocate abortion. It is not an option to these people. And I feel when I see somebody who has been there that they have been exposed to the other side.

And a lot is being said about informed consent. I think again it is a question of semantics. We spend a great deal of time when an informed consent form that is perfectly horrible. It throws the fear into patients just as they would like us to do. It does not include

perhaps specific details of exact sizes. That's the only difference——

Senator HATCH. Doctor, you and I both know one reason you do that is because of the potential of medical malpractice exposure. It is not necessarily to inform the patient of the moral and ethical and other problems involved with abortion. And, you have indicated that is so.

Now, let me just ask both of you doctors—you are both eminent people in your profession; you both perform abortions—do you agree with me, although it would not be an absolute panacea or problem-solver, that maybe the answer is in better family planning in this country, better family planning methods?

Dr. JONES. I was going to congratulate you, Senator, because you are one of the first people I have been exposed to who is willing to bridge the gap. We have tried to sit down and talk to the people who lead the pickets and things like this, and very frankly, they are the same people, and they don't want to talk about contraception. They fight sex education in the schools.

Senator HATCH. But you agree with me, then——

Dr. JONES. Completely.

Senator HATCH [continuing.] That contraception—not just contraception, but family planning across-the-board——

Dr. JONES. And I hope you will bridge the gap.

Dr. GERSTLEY. Absolutely. I have been involved in family planning, sex education in the schools, for years. I did it back in the Sixties and early Seventies, and then found it squeezed out by the Birch Society and similar groups, and would love to see it made available. It is absolutely necessary.

Senator HATCH. Wouldn't both of you feel a lot better if we never had to perform any abortions in society? Wouldn't both of you agree with that?

Dr. GERSTLEY. I would love it if we had never had the need for one. I have never asked anybody to come in. I have never wanted to do them, but I have recognized the need. As I said before, they have gone on from the beginning of recorded history, they are being done, and they are going to be done.

Senator HATCH. Well, this hearing has been very important to me because I have to say that I am very concerned, and I think any honest-thinking American citizen would have to listen to your last few words here, as well as to the prior words, that we have to be very concerned with 1.6 to 2 million abortions in a Judeo-Christian society like we have in this country. And, frankly, I cannot imagine any thinking person not being real concerned about that. It is a disgrace. And if there is some way we can get around that disgrace and prevent the unnecessary loss of human life, we ought to do that.

I want to thank Ms. Richard for coming in because I think in your own way, you have been the most eloquent witness we have had with regard to the pro life side of this thing in years around here. And, you, in your own way, having been there and realized what that did to you and the potential of what it could have done to you, and then going to your own God and working it out and receiving what you considered to be forgiveness, and then of course working as you do to understand more about human life, I want to

compliment you. I think you have done a good job in testifying here today, and you have helped all of us.

I just wish we could resolve this problem in a way that most people would feel good about. I agree that the two extremes are never going to feel good no matter what we do, unless they win their particular point of view. But the vast majority of American citizens would like to see this resolved short of total abortion on demand, and short of not allowing a wife or mother or a young woman whose life is in jeopardy to have an abortion. And, I think the vast majority would consider rape and incest as an exception—and I don't know, there may be some other qualifications—but I know that the vast majority of American citizens are not pleased with abortion on demand, with widespread, millions and millions of abortions in this country, especially since in most cases, real consent, real explanation, real discussion of the moral and ethical implications are really not even attempted.

So all I can say is I am going to keep an open mind and do the very best I can to try and bring both sides together—but I am a part of those who are trying to work out reasonable solutions—to see if we can resolve this matter so there don't have to be any abortions. And I don't think it is just a simple, easy answer to say that the French pill is going to do it or solve all our problems, either, because it won't.

To that extent, I want to thank all of the witnesses today for testifying, thank Senator Metzenbaum for having these hearings, and look forward to the future hearings.

Thanks so much.

With that, we'll recess until further notice.

[Whereupon, at 1:02 p.m., the proceedings were adjourned.]

THE FREEDOM OF CHOICE ACT

WEDNESDAY, MAY 23, 1990

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:38 a.m., in room SD-430, Dirksen Senate Office Building, Senator Howard M. Metzenbaum, presiding.

Present: Senators Metzenbaum, Simon, and Adams.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Good morning.

This is the second in a series of hearings relating to The Freedom of Choice Act. This legislation would codify the principles articulated by the U.S. Supreme Court in *Roe v. Wade* which guaranteed women the right to choose to terminate a pregnancy prior to viability in consultation with her doctor.

Today we will hear testimony from doctors, counselors and medical researchers about why women have abortions and the health effects of abortion regulations.

We will also learn how doctors determine viability. It is important to remember in this debate that our primary concern is in promoting women's health. Any regulation of medical procedures including abortion must be aimed at protecting and enhancing women's health and must not be simply a means of denying access to safe abortion services.

The chair wishes to point out that there will be a vote on the floor of the Senate at 10:15 a.m. Each of our witnesses has been advised that there is a 5-minute limit with respect to their presentations, but we are happy to have each of them with us; I know that many of you have come from long distances, but we will be rather strict in limiting you to the 5-minute period.

I would invite our first panel to the table. It consists of Dr. Jacqueline Darroch Forrest, Vice President for Research at the Alan Guttmacher Institute in New York; Dr. Ian Gross, Director of Perinatal Medicine, Yale Medical School in New Haven, CT; Dr. John Nelson, OB/GYN, Utah Medical Association in Salt Lake City, UT; and Dr. Richard Glasow, Director of Education of the National Right to Life Committee, Washington, DC. We are happy to heave each of you with us.

Dr. Jacqueline Forrest, would you please proceed?

STATEMENTS OF DR. JACQUELINE DARROCH FORREST, VICE PRESIDENT FOR RESEARCH, ALAN GUTTMACHER INSTITUTE, NEW YORK, NY; DR. IAN GROSS, DIRECTOR OF PERINATAL MEDICINE, YALE UNIVERSITY SCHOOL OF MEDICINE, NEW HAVEN, CT; DR. JOHN NELSON, PRESIDENT, UTAH MEDICAL ASSOCIATION, SALT LAKE CITY, UT, AND DR. RICHARD GLASOW, DIRECTOR OF EDUCATION, NATIONAL RIGHT TO LIFE COMMITTEE, WASHINGTON, DC

Dr. FORREST. Thank you, Mr. Chairman.

I am Jacqueline Darroch Forrest, Vice President for Research at the Alan Guttmacher Institute.

As you are considering national legislation that would guarantee access to safe, legal abortion to women in the United States, thank you for the opportunity to talk to you about who has abortions in the United States, why they have abortions, when, and really give you some of the context of some of that debate.

With your permission, I would like to insert into the record "Abortion: Women's Health", a publication that was published quite recently that summarizes much of the information that I will be presenting today.

Senator METZENBAUM. We will accept it; I'm not certain that we will reprint the entire matter in the record. I think we'd like to take a look at it. Certainly, we will accept it for the record, but without printing it.

Thank you.

Dr. FORREST. Thank you.

Certainly as we all know, abortion is not a new phenomenon. Estimates vary in terms of how many women had abortions before it became legal, but we know that many, many women had abortions then, often under degrading and unsafe circumstances.

Abortion also, as we know, is not a rare occurrence in the United States. That is true mainly because unintended pregnancy is so common in this country. About half of all pregnancies are unintended in the United States, and about half of those end in abortion. Of women in their early 40s today, two-thirds have had at least one unintended pregnancy, and at current levels of abortion, about half of women will have an abortion by the time they reach 45.

Senator METZENBAUM. Say that again, that last statement.

Dr. FORREST. Of women 40–44 in the United States today, two-thirds have had an unintended pregnancy. At current levels of abortion in the United States, women today who are beginning their teen years, by the time they are 45, 46 percent of them will have had at least one abortion.

Senator METZENBAUM. That is an incredible figure.

Dr. FORREST. It is an incredible figure. It comes from the fact that so many women have unintended pregnancies in the United States. And many women have even more than one unintended pregnancy and more than one abortion. Forty percent of all women having abortions are having a repeat abortion, have already had one before.

This comes primarily because so many women in the United States already have had an unintended pregnancy and abortion.

What distinguishes women having more than one abortion is really the fact that they are older and have had a longer period of time to have been exposed to unintended pregnancy.

One thing that legalization did that was very important was make abortion earlier so that now 9 out of 10 abortions in the United States happen in the first 12 weeks of pregnancy, a time when it is safer for the women concerned. Late abortions therefore are rare in the United States today. One-half of one percent occur after 20 weeks of gestation. One hundred to two hundred out of the 1.6 million abortions each year happen after 24 weeks of pregnancy.

These are troubling to everybody concerned, but there are reasons why these women are having abortions later—primarily because the women or the medical providers that they consulted had misjudged the timing of their pregnancy, whether they were pregnant at all or how far along they were, or because women had difficulty raising the money to be able to obtain abortions.

Prohibiting abortion late in pregnancy, past 20 weeks, would not affect large numbers of women but it would affect the most vulnerable women—those who are younger, poorer, who are pregnant because of rape or incest, or they are having an abortion because of a possible fetal abnormality.

Abortion occurs among all types of women in the United States. Variations across different groups of women in terms of which groups have higher levels of abortion really mirror levels of high unintended pregnancy so that young women, minority group women, poor women, unmarried women have high levels of unintended pregnancy, and high levels of abortion compared to other women.

At least half of women who have abortions report that they were using a contraceptive in the month they became pregnant; about 40 percent of the others say that what they were doing was not using a method at that time, but they had been using a method previously, often in the last month or two, but were not using one in the current time.

Women give multiple reasons why they have abortions. They give complex reasons that often reflect long-term problems rather than short-term considerations. Three-quarters say that they are having an abortion in part because they are concerned about how having a child at the time would interfere with their schooling, with their employment, with their ability to take care of other family members.

We know abortion is not new; it is not rare. It is an important issue in this country that affects all of us. At the same time there are a number of other issues that we need to look at in terms of unintended pregnancy that are causing these high levels of abortion.

If we are really concerned about trying to prevent abortion, we have to get to the root of the issue, which is preventing unintended pregnancy. I think that it is very appropriate in the wake of the *Webster* decision that your committee is considering the conditions under which women can have abortions, but I think it is also very important that attention be given to preventing unintended pregnancy and therefore preventing abortion in that same debate.

While preventing unintended pregnancy is not the only component of abortion, it is one of the key components, and any efforts really to reduce abortion have to increase education about contraceptive use and the methods available for it.

Senator METZENBAUM. Thank you very much, Dr. Forrest.

[The prepared statement of Dr. Forrest follows:]

PREPARED STATEMENT OF JACQUELINE DARROCH FORREST

Senate Testimony on Freedom of Choice Act, May 23, 1990

Thank you Mr. Chairman. I am Jacqueline Darroch Forrest, Vice President for Research of The Alan Guttmacher Institute (AGI), an independent, nonprofit corporation for research, policy analysis and public education in matters related to reproductive health and population. On behalf of AGI, I would like to express my appreciation for the opportunity to appear before you today at this hearing on the Freedom of Choice Act and to provide the committee with some statistical and demographic context in which to consider national legislation guaranteeing access to legal abortion. My remarks will focus on an analysis of the incidence of abortion, who has abortions, why and when.

Incidence of Abortion

It would be a mistake to think that abortion is a new phenomenon in the United States. Estimates of the number of abortions that were occurring here each year before services became legally available in the early 1970's vary (from 200,000 to 1.2 million), but there is little question that many women were indeed having abortions then, often under degrading and unsafe conditions.

Neither is abortion a rare occurrence in the United States. This is so because unintended pregnancy is relatively common in our country. Each year, 11 percent of American women between the ages of 15 and 44 become pregnant. Over half of all pregnancies (54 percent) are unintended. This means that,

annually, six percent of women aged 15-44 face an unintended pregnancy. Roughly half of these women choose to and are able to obtain abortions. The result is that three percent of all women aged 15-44 have an abortion, an annual level that has remained quite stable since the late 1970's, with approximately 1.6 million women in the United States having abortions each year.

Another way to assess how common abortion is in the United States is to ask what proportion of women have ever had an induced abortion and how many will probably do so during their reproductive lives. One must rely on estimates here because abortions are underreported in surveys of women in the general population, such as the National Survey of Family Growth (NSFG) conducted by DHHS' National Center for Health Statistics. (This is a general problem of surveys, not specific to NSFG.) Thirty-nine percent of women aged 15-44 who were surveyed in the NSFG in 1982 reported they had had at least one unintended pregnancy and 10 percent reported they had had an abortion. Combining these data with AGI research on the actual number of abortions that occurred in the country, I have estimated that in fact 46 percent of women aged 15-44 had had an unintended pregnancy and 21 percent - one in five - had had an abortion. This averages together young women who have not yet completed their reproductive lives and older women who passed through most of their reproductive lives before abortion became legally available.

Among women who were aged 40-44 in 1982, an estimated 65 percent had had at least one unintended pregnancy. I have estimated that, at today's levels of abortion, 46 percent of American women will have an abortion before age 45 -- implying that 70 percent of women who experience an unintended pregnancy will have at least one abortion.

Some women experience more than one unintended pregnancy and more than one abortion. Current abortion rates in the U.S. imply an average of 76 abortions per 100 women over their total reproductive lives. About 40 percent of all women having abortions have had more than one. This is a high number, but it is not especially surprising. As more time passes during which legal abortion is available in this country, and as long as the high rates of unintended pregnancy persist, the likelihood of repeat abortion is fairly high. Numerous studies have examined the characteristics of women who have repeat abortions. There is no evidence that they are any different from women having their first abortions either psychologically or in their attitudes toward or use of contraception. What most distinguishes women having a repeat procedure from women having a first abortion is that they are older and have had a longer time to have already had an abortion.

When Women Have Abortions

Since 1973, the proportion of all abortions taking place very early in pregnancy (within the first eight weeks since the women's last menstrual period) has risen dramatically to half of all abortions. This has been

associated with the increase in availability of abortion services since abortion service provision became legal. Since the mid-1970s, the vast majority of all abortions, some 91 percent, have been performed during the first twelve weeks of pregnancy, when the procedure is safest.

"Late" abortions are rare. One-half of one percent of all abortions take place past twenty weeks, and only 100-200 abortions nationwide occur after 24 weeks. But the fact that they do occur is troubling to many people, not least of whom are the women who obtain them and the medical teams providing them. One study of women having an abortion at 16 or more weeks since their last menstrual period found that the women's most common reason for not having had the abortion earlier was that she, and sometimes a medical provider she had consulted, had not realized she was pregnant or had misjudged the time of gestation. Another common reason was that the woman had difficulty in making arrangements for the abortion. This usually was attributable to the time it took to gather the money necessary to pay for it.

Any prohibition on abortion after 20 weeks would not affect large numbers of women, but it would have its greatest impact on the most vulnerable women in our society and upon those for whom the American public has the greatest sympathy in their decision to have an abortion. The women who have abortions after 15 weeks of pregnancy are disproportionately under age 18, black, unemployed, poor enough to be eligible for Medicaid, or pregnant as a result of rape or incest. They are also more likely than other women to be having abortions because of possible fetal health problems. Amniocentesis,

the most common test to diagnose fetal defects, usually does not yield results before 18 or 19 weeks of pregnancy, so almost all abortions for this reason occur after 20 weeks. Americans consistently and strongly have indicated that they believe abortions should be available in this situation.

Characteristics of Women Who Have Abortions

An estimated 16 million women have had abortions in the U.S. since it became legal, and many, many others obtained abortions when it was illegal. It is significant to note that women of all ages, races, religions and economic backgrounds seek abortions, but it is instructive for public policy reasons to recognize that certain groups have higher abortion rates than others.

While each year three percent of all women aged 15-44 have abortions, the proportion within different groupings of women varies widely depending on women's characteristics and circumstances. Many states collect information on the characteristics of women who have abortions that have been compiled and published since 1969 by DHHS' Centers for Disease Control. More detailed information from a small number of states has been compiled and published since 1977 by DHHS' National Center for Health Statistics. In 1987, under a grant funded by NICHD, AGI surveyed a national sample of 9,480 abortion patients in 103 clinics, hospitals and doctors' offices in all parts of the United States. Those data are not only the most recent information available on who has abortions but also cover characteristics which have not been

included in the other data systems. One important finding is that there was no category of any characteristic investigated in the study for which no patients were found. Not only is abortion a fairly common occurrence in the U.S. but it is an experience that touches all groups of women.

This study found that the proportion of women under age 30 having abortions is greater than the U.S. average of three percent per year. Abortion rates are higher among nonwhites and Hispanics than among whites and non-Hispanics. They are highest among women reporting no religion and lowest among Jewish women. Roman Catholic women have abortions at rates equal to the national average. Protestant women and evangelicals have abortions at below average rates. Rates among unmarried women are higher than those currently married. We found women who are enrolled in school or working have higher abortion rates than those not in school or not working. More than six percent of women with annual family incomes below $11,000 have abortions each year, compared to slightly more than three percent of those with incomes between $11,000 and $24,999 and less than two percent of higher income women.

The study showed that 51 percent of the abortion patients had been using a contraceptive method during the month in which they had become pregnant, 40 percent had been previous users, often fairly recently, and nine percent had never used a contraceptive method. Non-use was most common among patients who were young, poor, black, Hispanic and less educated.

Recently, I compared the patterns of contraceptive use reported by women in this survey with data on contraceptive use in the United States as a whole in 1987. I found that among those women aged 15-44 who are sexually active and physically able to become pregnant who are not trying to have a child, each year four percent have abortions (compared with the three percent of all women). The rate varies from close to zero percent of those relying on contraceptive sterilization to less than two percent of those using oral contraceptives and 23 percent of those using no method.

Differences in the level of abortion across groups of women come about because of differences in the rates of unintended pregnancy and differences in the proportions of women who decide to and are able to obtain abortions to resolve their unintended pregnancies. The study I just described did not identify the relative contributions of these two factors to disparities in abortion rates across subgroups. In general, however, many of those groups of women with high abortion rates (e.g., young, unmarried, nonwhite, Hispanics, poor women) have been shown in other studies to be more apt to experience unintended pregnancies, primarily because of relatively low levels of contraceptive use, and also because of higher failure rates while using contraceptives.

Variations in abortion rates and in the proportion of unintended pregnancies that end in abortion become a bit clearer when we look at the stages of women's reproductive lives. By age 17.4, half of U.S. women have had intercourse, but it is not until almost six years later (23.2 years old)

that half of women have married. Sixty-three percent of abortions occur to women in this stage, i.e. sexually active but never married. By age 30, half of U.S. women have had all the children they desire, but they face 19.8 years before age 49.8 when half will reach natural menopause. Pregnancy rates are lower in this life stage, to a large extent because of surgical sterilization for contraceptive or medical reasons, but many of those who do become pregnant opt for abortion. Thirty percent of abortions are obtained by such women who have a pregnancy after they have completed their families.

Reasons Women Have Abortions

As noted earlier, about half of all women with unintended pregnancies have abortions. Another recent AGI study investigated the reasons these women opt for abortion. This study surveyed 1,900 women who had abortions in a sample of 30 facilities around the country between November 1987 and March 1988.

These women reported that they had multiple reasons for choosing abortions. Ninety-three percent gave more than one reason; the average number was 3.7. The reasons were complex, and they did not group together into similar patterns for many women. The most common ones reflected the fact that many women have unintended pregnancies before they are ready to begin a family. Three-quarters of the women said they had opted for an abortion

because they were concerned about how a baby would change their life, primarily that it would interfere with their job, employment or career or that it would interfere with attending school. Two-thirds said they chose abortion because they could not afford to have a baby at the time, and half because of relationship problems. Other reasons, each cited by at least a quarter of women, were that they were not ready for the responsibility of having a child, didn't want others to know they had had sex or become pregnant, felt too immature or too young to have a child or that they had grown-up children or all they wanted to have.

The picture that emerged from this study was one of women who feel that although they are pregnant, they are not able to have a child yet or to have another child. It is a picture of women considering multiple, complex and often long-term problems that would affect their ability to be good parents and that would affect their lives and the lives of other family members. This study looked only at women who had chosen to seek and were able to obtain abortions. It did not investigate the extent to which those women with unintended pregnancies who gave birth faced different circumstances, viewed them differently or had different attitudes about abortion as an option or were less able to obtain access to services. It is obvious, however, that studies comparing outcomes of women having abortions with those who give birth and with those who are not pregnant must control for such differences. Assessments of psychological effects of abortion must pay attention as well to separating out the effects of women's experience with and reaction to their pregnancies.

It is also very important to remember that although the vast majority of abortions result from unintended pregnancies, some occur to women who very much wanted to become pregnant and to have a child. Instead, these women were confronted with unexpected events such as a personal or fetal health problem, a relationship that ended or the loss of financial support because of unemployment. The psychological impact of abortion in such cases is probably different from those in which the pregnancy was unintended.

Finally, once a woman makes the often very difficult decision to obtain an abortion, it is highly relevant to keep in mind that her ability to act on that decision is ultimately controlled by external factors. Access to abortion services varies depending on where women live, the attitudes of medical providers they may turn to for help, their age and their income. Those women who seek help to confirm that they are pregnant, to decide whether to have an abortion or not and to obtain abortion services may also encounter harassment at the medical facility. AGI research indicates that facilities serving 83 percent of abortion patients in 1985 were subject to harassment. The most common forms were picketing and noisy demonstrations. While harassment may be directed primarily at the provider, it is unlikely these women are unaware or unaffected by it.

Conclusion

Mr. Chairman, after almost twenty years of legal abortion in the United States, there is still a great deal we have to learn about it. But there are certain things we do know that should guide your deliberations as you consider national abortion legislation.

- o Abortion is neither a new nor a rare occurence in the United States.

- o The trend toward obtaining abortions earlier in gestation means that now nine in ten are performed within the first twelve weeks of pregnancy.

- o Unintended pregnancy and abortion are events that occur to all types of women, but most particularly to those who are young, poor, unmarried, black and Hispanic.

- o Those women with unintended pregnancies who have abortions do so for multiple, complex reasons that lead them to conclude that they cannot or should not have children yet or have more children.

If I may, Mr. Chairman, I would like to make one final, overriding point. While the number of abortions performed in the United States each year has remained basically stable for over a decade now at about one-and-a-half million, the fact that one-quarter of all pregnancies end in abortions reflects the persistent high levels of unintended pregnancies we have in this country. At some point, we as a society, are going to have to face up to the fact that if we really want to do something to bring down the number of abortions we are experiencing, we are going to have to do something to bring down the number of unintended pregnancies.

In that light, what concerns me in the wake of the Webster decision is not so much that the conditions under which women have abortions are a central issue in a national policy debate, but that prevention of unintended pregnancy and of abortion is seldom mentioned in that debate. While not the total answer, a key component of any national response to high rates of abortion should be expanded and improved contraceptive use by those who are having sex and not wanting to become parents. This must include not only expanded access to contraceptive services but also better education of those using contraceptives as well as more research in order to expand and improve the array of methods available.

Reauthorization of the Title X family planning services program, as reported by your committee, would be an important step toward each of those goals, and Congress should delay passage of this legislation no longer. Even as Congress moves to protect women's access to legal abortion through consideration of the Freedom of Choice Act, it must also recommit itself to prevention.

Senator METZENBAUM. Dr. Gross, we are happy to hear from you.

Dr. GROSS. Thank you, Senator, for this opportunity to address the committee.

I am currently a professor of pediatrics and director of perinatal medicine at Yale University and director of the newborn special care unit at Yale New Haven Hospital. I am a neonatalogist, or a specialist in the care of sick newborns, and for the last 16 years of my professional life I have been doing just that.

My research has focused on fetal lung development. From 1981-85, I served as a member of the human embryology and development study section at the National Institutes of Health, where my role was to review research proposals in that area. I am here today in my personal capacity.

I was asked to discuss the limits of fetal viability. When one asks this question, one is really attempting to define what is the earliest age that those fetuses that mature the most rapidly can survive outside the womb.

Advances in obstetrics and neonatal intensive care have resulted in dramatic improvements in the survival of premature babies. In the early 1960's, before the advent of neonatal intensive care, about 70-80 percent of babies who weighted between 2 to 3 pounds would die. Today, 80-90 percent of those babies survive. This is unquestionably one of the major accomplishments of modern pediatrics.

Grateful parents will often contact the media to tell them of the survival of their "miracle" baby, and we in the medical profession are usually quite happy to cooperate in the dissemination of the reports of these "miracles" because it reflects well on our efforts.

We have, however, contributed to what is, I think, at times entirely unrealistic expectations of the possibility for fetal survival.

All humans are not the same. Just as children vary in the rate at which they grow and mature after birth, so fetuses differ in the rate at which they mature before birth. There are, however, finite limits to the rate at which humans grow and mature both before and after birth.

The situation with regard to fetal viability is complicated by the fact that the most premature infants cannot survive on their own. They require medical care. Thus their survival is determined by at least three factors—(1) the State of maturity of the infant at birth; (2) the skill and the aggressiveness of the medical care that they are provided—and by "aggressiveness" I mean enthusiasm—and (3) the State of the art of obstetric and pediatric technology.

Numerous medical reports have been published describing the survival rates of very premature infants. I will refer to three sources to review this information: First, the Report of the Committee on Fetal Extrauterine Survival to the New York State Task Force on Life and the Law, which was published in 1988; second, a report from Rainbow Babies and Children's Hospital in Cleveland, which was published in the *New England Journal of Medicine* in December 1989; and third, our own data from Yale.

I chose the Cleveland data as that unit has a very aggressive approach to the management——

Senator METZENBAUM. Which institute in Cleveland was that?

Dr. GROSS. Rainbow Babies and Children's Hospital; it is affiliated with Case Western Reserve.

Senator METZENBAUM. Thank you.

Dr. GROSS. The Cleveland unit has traditionally reported high rates of survival of premature infants and has a fairly aggressive approach to their management.

We at Yale also have an active and positive approach to these infants. It is our policy that except in most obvious cases, decisions regarding viability should not be made in the delivery area—that is, where the woman has just given birth—but rather, that resuscitation should be initiated on all liveborn infants, who are then brought over to our intensive care unit.

In the intensive care unit, the more careful determination of potential for survival can be made. If we feel that there is a chance for survival, intensive care will be initiated. The determination of whether to proceed is based largely on the infant's response to the resuscitative measures that have been provided so far.

I have listed survival rates by birth weights in Table 1 which is attached to my report. It is generally felt that statistics which are based on birth weights are more reliable than those which list survival by gestational age or duration of pregnancy. Weight is an objective measurement where gestational age is a clinical assessment which is subject to error.

Survival of babies who weigh less than 500 grams, which is just less than one pound—450 grams is a pound—is an extremely uncommon event. Those babies that do survive may in part be small not only because they are premature, but also because they have not grown adequately in the womb; that is, they may be more mature than their weights would suggest.

If you go to babies weighing between 500 and 600 grams, about 5–10 percent will survive. Above 600 grams, survival starts becoming more frequent.

As I said earlier, assessment of survival by gestational age is less precise, as shown in Table 2, which is attached to my report. Babies of 22 weeks estimated gestational age have been reported to survive, but this is a very rare event. Occasional babies survive at 23 weeks. By 24 weeks, rates of 10–20 percent may be achieved with the most intensive efforts.

These statistics reflect survival with existing technology. The report from Cleveland was disappointing in that although their unit had in recent years become even more active in managing these infants, they had not succeeded in significantly improving survival; they had merely prolonged the time that the babies took to die. It appears that we have reached the limits of the potential of our current technology.

Although immaturity of many organs contributes to the inability of the smallest babies to survive, the lungs probably play the major role. A number of developments have occurred recently in an attempt to improve pulmonary activity in premature babies. These include the provision of a chemical substances known as surfactant; attempts to bypass the lungs altogether, and other techniques. None of these I believe have shown immediate potential for prolonging the survival of premature infants.

Senator METZENBAUM. Thank you very much, Dr. Gross.

[The prepared statement of Dr. Gross follows:]

Report to the Committee on Labor and Human Resources, United States Senate, by

Dr. Ian Gross

Re: S.1912, the Freedom of Choice Act of 1989.

I am currently Professor of Pediatrics and Director of Perinatal Medicine at Yale University School of Medicine and Director of the Newborn Special Care Unit at Yale-New Haven Hospital. As a neonatologist, or specialist in the care of newborn infants, I have committed the last 16 years of my professional life to the care of sick newborns. My research has focused on fetal lung development. From 1981 to 1985 I served as a member of the Human Embryology and Development Study Section of the National Institutes of Health, where my role was to review research proposals in that area. I am here in my personal capacity and not as a representative of any institution.

I was asked to discuss the limits of fetal viability. When one considers this question one is really attempting to define the earliest age that the most rapidly maturing fetuses can survive outside the womb.

Advances in obstetrics and neonatal intensive care have resulted in dramatic improvements in the survival of premature babies. In the early 1960's 70-80% of babies weighing between 2-3 lbs died. Today 80-90% of these infants survive. This is unquestionably one of the major accomplishments of modern pediatrics. Parents often contact the media to tell them of the survival of their "miracle" baby and we in the medical profession are usually quite willing to cooperate in the dissemination of the reports of these modern day "miracles" as it reflects well upon our efforts. We have however contributed to what are, at times, entirely unrealistic expectations of the possibilities for fetal survival.

All humans are not the same. Just as children vary in the rate at which they grow and mature after birth, so fetuses appear to differ in the rate at which they mature before birth. There are, however, finite limits to the rate at which humans grow and mature both before and after birth. The situation with regard to fetal viability is complicated by the fact that the most premature infants cannot survive on their own. They require intensive medical care. Thus their survival is determined by at least 3 factors:

1. The state of maturation at birth

2. The skill and aggressiveness of the medical care that they are provided

3. The state-of-the-art of obstetric and pediatric technology

Numerous medical reports have been published describing the survival rates of very premature infants. I will refer to 3 sources to review this information: The Report of the Committee on Fetal Extrauterine Survival to the New York State Task Force on Life and the Law, published in 1988 (1); a report from Rainbow Babies and Childrens Hospital, Cleveland, published in the New England Journal of Medicine in December 1989 (2); and our own data from Yale (3). I chose the Cleveland data as that unit has an aggressive approach to the management of premature infants and has traditionally reported high survival rates. We too have an active and positive approach to these infants. It is

our policy that, except in the most obvious cases, decisions regarding viability should not be made in the delivery area, but rather that resuscitation should be initiated on all live born infants who are then brought over to our intensive care unit. In the intensive care unit a more careful determination of potential for survival can be made. If there is felt to be a chance that the infant will survive, intensive care is provided. This determination is based largely on the infant's response to resuscitative measures.

Survival rates by birthweight are listed in Table 1. It is generally felt that these statistics are more reliable than those which list survival by gestational age. Weight is an objective measurement, whereas gestational age is a clinical assessment which is subject to greater error. Survival of babies weighing less than 500 grams (just over 1 pound) is an extremely uncommon event. (Those babies that do survive may, in part, be small because they have not grown adequately in the womb i.e. they may be more mature than their weight would suggest.) 5-10% of babies weighing between 500-600 grams survive. Above 600 grams survival becomes more frequent.

Assessment of survival by gestational age is less precise. As is shown in Table 2, babies of 22 weeks estimated gestational age have been reported to survive, but this is a rare event. Occasional babies survive at 23 weeks. By 24 weeks rates of 10-20% may be achieved with the most intensive efforts. (I have focused here only on survival and not on the complications or nature of that survival as this does not seem relevant to today's presentation. Many of the very smallest infants survive with significant handicap.)

These statistics reflect survival with existing technology. The report from Cleveland was disappointing in that although their unit had in recent years become even more active in the management of these infants, they had not succeeded in significantly improving survival. They had merely prolonged the time that the babies took to die. It appears that we have reached the limits of the potential of our current technology.

Although immaturity of many organ systems contributes to the inability of the smallest babies to survive, the lungs probably play the major role and a number of new technologies have been developed to support breathing. However, before 23 weeks the lungs are just not formed structurally so that they can function adequately, even with the assistance of a ventilator (4). Clinical trials have recently been performed to study the effects of the replacement of a chemical substance, known as surfactant, which is deficient in the lungs of many premature infants, but it is unlikely that the provision of this substance can compensate for failure of the lungs to develop structurally. New types of ventilators, known as high frequency ventilators, have proven disappointing for the routine treatment of babies with lung immaturity. Attempts to bypass the lungs altogether and to accomplish gas exchange artifically, outside the body, by a procedure known as ECMO (Extracorporeal Membrane Oxygenation) have proven useful for some bigger babies, but not for the small prematures who suffer severe complications from this procedure. What these babies really need is the equivalent of an artificial placenta and an artificial uterus, but these developments are futuristic and not in the realm of current medical technology.

I am sometimes asked to comment on rumors that a 16 week fetus has survived. (It is unfortunate that such events do not seem to occur in major medical centers where they could be studied and confirmed.) My response to

this would, I think, be the same as that of committee members if you were informed that someone had seen a 5 year old child who had grown so rapidly that he/she was now 12 feet tall or a 2 month old baby who had matured so rapidly that he/she could speak fluently. Such an event would be completely inconsistent with your personal experience or anything you had read other than in a supermarket tabloid. You would probably be highly skeptical. I suspect that such reports of amazing fetal survival are due to incorrect estimation of gestational age.

In summary, with the best care available, babies occasionally survive at 23 weeks and very, very rarely before then. For all practical purposes 23-24 weeks and 500-600 grams may be regarded as the current limits of fetal extrauterine survival and I am not aware of any technologies on the horizon that are likely to significantly change this.

References

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3. Ehrenkranz, R.A. Survival statistics, Newborn Special Care Unit, Yale New Haven Hospital (1990). Unpublished.

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Table 1. Neonatal Survival by Birth Weight

Birth weight:	New York State Report 1978 - 1984	Cleveland 1982-1985	Cleveland 1985-1988	Yale 1979-1988	Yale 1989
Less than 500 grams*		0% (0/21)	2% (1/40)	0% (0/163)	0% (0/16)
500-600 grams**	5-10%	10% (3/29)	0% (0/36)	6% (5/82)	0% (0/10)
600-700 grams	10-15%	13% (4/32)	33% (10/30)	26% (36/138)	46% (6/13)
		700-750 grams			
700-800 grams	25-45%	81% (13/16)	52% (12/23)	42% (51/122)	56% (5/9)
800-900 grams	35-55%			63% (77/123)	77% (10/13)
900-1000 grams	60-80%			75% (94/125)	67% (10/15)

*480 grams = 1 pound
**500-600 grams = about 24 weeks of gestation

Table 2. Neonatal Survival by Gestational Age

Gestational Age	Cleveland 1982-1985	Cleveland 1985-1988	Yale 1984-1989	Yale 1989
21 weeks	0% (0/5)	0% (0/20)		
22 weeks	0% (0/9)	5% (1/20)	<24 1% (1/127)	0% (0/27)
23 weeks	13% (2/15)	5% (1/22)		
24 weeks	16% (4/25)	15% (4/26)	8% (3/39)	20% (1/5)
25 weeks	41% (17/41)	64% (25/39)	34% (23/67)	36% (4/11)
26 weeks	53% (18/34)	71% (34/48)	58% (28/48)	75% (6/8)
27 weeks	65% (20/31)	76% (39/51)	70% (46/66)	56% (5/9)
28 weeks			83% (87/105)	100% (12/12)

Senator METZENBAUM. Dr. Nelson, we are very happy to have you with us this morning.

Dr. NELSON. Thank you, Mr. Chairman, and good morning.

My name is John C. Nelson, M.D., from Salt Lake City. I am in the private practice of obstetrics and gynecology. I am a Fellow of the American College of Obstetricians and Gynecologists, a clinical associate professor at the University of Utah. I am an original Prospective Payment Assessment Commissioner, and I am president of the Utah Medical Association. In that latter capacity as I speak today, if my remarks differ from the association's position, I'll make that clear.

It is my concern today, Mr. Chairman, to talk about the medical aspects of the proposed legislation.

The Utah Medical Association's position provides that it opposes legislative proposals to use Government moneys to deny established and accepted medical care to any segment of the population; it States that abortion is a medical procedure and should be performed only by a duly-licensed physician; and it States that no one should be required to perform an act violative of their own personal moral principles, and that as such a physician should be able to withdraw from an abortion case if he or she chooses.

I would point out, sir, that the main point I'd like to make today is the difference in technology that has changed over the last several years. Specifically and briefly, I will mention only the use of ultrasound which, in my own practice, has affected at least three cases in a major way—one in which the infant had hydrocephaly which was picked up antenatally; the infant, delivered by Cesarean delivery and with a shunt in the child's head, has done very well. Second, an abdominal mass so large that it can press the fetal chest, making the heart go into failure, which was found early. Mother and baby did fine after a Cesarean birth. Perhaps the most spectacular case was the young infant who had a heart defect which was absolutely lethal. That heart defect was picked up antenatally; the mother was shifted to a university in California where she was delivered by Cesarean section at the appropriate time, and the infant underwent a successful heart transplant. This is very impressive, if you will, technology.

The reason for bring that up, Mr. Chairman, is that when the U.S. Supreme Court talked about viability in 1973, the issue was much different than it is in 1990. I have a very difficult time personally reconciling my role as a physician and attempting to protect survival of these infants using the very significant sophisticated technology we have and the proposed intent of the legislation.

There are a couple of areas that I am very concerned about. First of all, I am concerned that S. 1912 will not allow for the appropriate role of informed consent, without which the physician has no legal protection and is very vulnerable. As you may be aware, liability is already a significant problem for those of us in my specialty.

Parental notification, in my opinion, should not be left out in this area inasmuch as no other procedure is allowed young people without their parents' consent.

I am very concerned about the fact that physicians need to in fact be the people who do this procedure. Very serious complica-

tions are potential, such as hemorrhage, perforation, infection; if too much tissue is removed from the uterine cavity, the two halves of the uterus can actually scar shut, a situation known as Asherman's Syndrome. This is rare indeed but in fact needs to be recognized, and I suggest that only those who are trained to do this procedure should be allowed to do so.

It is also incredibly important that a pathology report be found. Not only is it important to make sure that the tissue received is as said to have been but it can also rule out such things as a tubal or ectopic pregnancy and in fact even cancer of the uterus. Medical records are absolutely essential if indeed the intent is to have appropriate medical care for the health of the woman. We need the medical records so that in fact we can follow the patient.

Perhaps the biggest concern though, personally, Senator, is the fact that the law would not provide for me as an individual to withdraw my own personal care from a patient who required or decided that she wanted to have this procedure done. I am a participating physician in Medicare. I have always seen and will continue to see Medicaid patients. In my State, I put together a coalition to deal with those people who have no insurance so that they, too, might receive care.

I also come from a State with a large rural population, and I am concerned, Mr. Chairman, that if we are not careful, what we are going to do is to deny access to many of these patients because of the very concerns that I have.

Indeed, sir, if it is forced upon me to have to do a procedure which would violate my conscience, I will cease the practice of medicine, thereby making one less Medicare physician, one less Medicaid physician, one less physician who will care for those people in the rural areas. I suggest that my specialty is already under very severe seige by the people in the legal profession. We need these safeguards so that we can give not only appropriate medical care but so that we can provide access to those who need the care.

In summary, then, I suggest that this bill is yet another inappropriate intrusion into the care of the patient and puts one more wedge between my patient and me—something that in my opinion is the antithesis of what is needed in medicine today.

Thank you very much.

Senator METZENBAUM. Thank you very much.

[The prepared statement of Dr. Nelson follows:]

Testimony before the Senate Labor and Human Resources Committee on S. 1912, "The Freedom of Choice Act of 1989."

Given by John C. Nelson, M.D., FACOG
President of the Utah Medical Association

My name is John C. Nelson, M.D. I am an obstetrician and gynecologist in private practice in Salt Lake City, Utah. I am board certified by the American Board of Obstetricians and Gynecologists and am currently a Fellow in the American College of Obstetricians and Gynecologists. I am a clinical Associate Professor of Obstetrics and Gynecology at the University of Utah College of Medicine in the Department of Obstetrics and Gynecology. I am currently honored to serve as the President of the Utah Medical Association. I have served as a Commissioner for the federal Prospective Payment Assessment Commission or ProPAC. It is an honor and a privilege to address the Committee today.

I will speak today as a physician - specifically trained in obstetrics and gynecology and as a representative of the Utah Medical Association. If my remarks differ from the official position of my Association, I shall attempt to make that point clearly.

Obstetrics is the portion of medical practice that deals with the pregnant female, as well as the delivery of the infant and other medical conditions which have an effect on the pregnancy, the mother, or the fetus. Gynecology is the part of medical practice which deals with the health aspects of female reproduction and conditions which affect the reproductive system of the female. A broader definition would also include other aspects of women's health care including counseling, her emotional well-being, and hormonal evaluation and therapy.

The point of discussion today is S. 1912, "The Freedom of Choice Act of 1989." Let me make clear that I understand the intent of this bill is to codify the principles behind the Roe v. Wade decision of 1973. As a physician, I express serious concerns about the proposed legislation.

The policy of the Utah Medical Association regarding abortion does the following:

1. Opposes legislative proposals to use government monies to deny established and accepted medical care to any segment of the population.

2. States that abortion is a medical procedure and should be performed only by a duly licensed physician, and

3. States that no one should be required to perform an act violative of their personal moral principles and as such a physician should be able to withdraw from an abortion case.

I shall attempt to address some of the specific concerns that I have as a practicing physician.

First, I am always concerned about the relationship between a physician and a patient. This is the hallmark of the profession. There are already too many intrusions into this delicate, sensitive, and private interaction. I refer to the interposition of third-party insurance companies, state and federal government regulations, and various kinds of health delivery mechanisms.

A physician makes a diagnosis by a specific process of taking a medical history, performing a physical examination, and obtaining appropriate laboratory data. By assimiliating the information presented, the doctor then formulates a clinical impression or diagnosis. At this time, a plan for treatment is devised and shared with the patient. The diagnosis, how it was obtained, other possible diagnoses, a plan for therapy as well as alternatives to the proposed therapy, risks and benefits of the proposed therapy, and the costs of the therapy are then discussed. Questions are solicited from the patient and answers are shared. At this point, the patient makes a choice as to whether he/she will accept the recommendation. It is not unusual to ask for another opinion before embarking upon a course of treatment, especially in complicated cases. I have just described the method by which physicians perform their clinical duties.

It is important to note that approximately 85 percent of the information upon which the diagnosis is based comes from the history. About 10 percent of the diagnoses are made after the physical examination, and the remaining 5 percent are made after laboratory evaluation. That means that by far the most information the clinician receives in order to make the correct diagnosis and initiate appropriate therapy comes from <u>what the patient tells the doctor</u>. It is clearly evident that any barrier to full disclosure to the physician is an inappropriate hurdle that ultimately may result in poor care for the patient through no fault of the physician.

I have been in practice since 1975. My specialty has changed dramatically in that time. I recall patients in my own practice who have been the beneficiaries of rapidly improving technology and innovations which were simply not available when I first began to practice.

To illustrate this point, let me discuss the methodology by which fetal gestational age is assessed. The initial method for knowing the gestational age of an infant comes from the medical history. The patient is asked to recall the first day of her last normal menstrual period (LMP). From that date, the physician subtracts three (3) months and adds seven (7) days to calculate the estimated date of confinement, the EDC of "due date." It is known that the time from the LMP to the EDC is exactly forty (40) weeks. Therefore, the normal pregnancy is forty (40) weeks, two hundred eighty (280) days, nine (9) calendar months, or ten (10) lunar months. By knowing these facts, it is possible to estimate the gestational age of a pregnancy.

Example:

If a menstrual cycle began today, one would calculate the EDC as follows:

LMP is 5/23/90

subtract 3 months: (5th month - 3 months) = 2nd month or February

add 7 days: 23 + 7 = 30

Therefore, the EDC would be February 30, 1991. Since February has only 28 days, the real EDC would be March 2, 1991.

With this very simple amount of information, the physician can begin to assess the age of the infant while still in utero.

The second very simple thing to do is to measure the height of the uterus (the fundus) in centimeters as it grows above the pubic bone (pubic symphysis). From the 16th week of the pregnancy until about the 35th week of the pregnancy, the fundal height will approximate the week of gestation. Therefore, a 20 cm. measurement will suggest a gestational age of about 20 weeks.

When one adds the modality of ultrasound, the accuracy of the evaluation increases markedly. The skilled ultrasonographer or perinatologist will be able to assign a gestational age that is very accurate. If serial examinations are performed, then the accuracy is improved even further.

Sometimes, it is necessary to know the gestational age exactly. When this is the case, one can perform an amniocentesis. This procedure involves the placing of a small, sterile needle through the maternal abdominal wall and into the uterine cavity inside the amniotic sac. This is usually done with a small amount of local anesthesia which numbs the skin of the mother, but has no effect on the infant. Ultrasonic guidance of the needle assures the well-being of the fetus. With negative pressure, a small amount of amniotic fluid is removed and sent to a laboratory for analysis. The whole procedure takes only a few seconds.

The fluid can be analyzed for several different components. A common test performed is the lecithin to sphyngomyelin ratio, or L/S ratio. When this number exceeds 2.00, it is usually indicative of fetal lung maturity. A second test done is for the presence of a chemical called phosphatidylglycerol, or PG test. The PG is said to be positive when this breakdown product of the other components is found in the amniotic sac. These sophisticated chemical tests are used for determining how much surfactant is present in the fetal lungs.

Surfactant is a substance that allows the surface tension to be markedly decreased in the microscopic airsacs in the fetal lung called alveoli. In the absence of surfactant, the fetal lung may collapse

any time the infant attempts to breathe out. The infant struggles with breathing which may lead to respiratory distress syndrome (RDS). If the disease is severe enough, it may lead to fetal death. At autopsy, the fetal lung tissue has a glassy or hyalinized appearance. This condition is called hyaline membrane disease (HMD).

Since the lungs are some of the last organs to mature, if the clinician is able to detect the maturity of the fetal lungs, then it can be safely assumed in most cases that the infant is mature. This knowledge is essential in the appropriate care of the preterm or premature neonate.

The successful treatment of the very immature neonate is a dramatic and impressive story in the annals of medicine. With very highly complex medical technology and amazingly well trained and caring personnel of several disciplines, the survival of these infants continues to improve. While it is true that these very tiny infants could not survive in the extrauterine environment without the artificial means of life support, the care given to them in the immediate few minutes after birth is the key to how well they will do later on.

At LDS Hospital and the University of Utah Medical Center, both hospitals at which I practice, there is the availability of an exciting new medication which increases the survival of many of these immature infants. By protocol, bovine surfactant is available. It is nebulized and sprayed into the trachea of these infants as they are being resuscitated. The surfactant seems to have the ability to prevent some of the severe forms of RDS. It would almost appear that many of these infants are clinically older than their known gestational ages. There is an apparent increase in the survival of the infants who receive the medication compared to those who do not receive it.

Of course, the better way to treat the immature neonate is to keep the infant in the uterus in the first place. Certain known conditions predispose patients to deliver early. Any time a uterus distends too rapidly, the irritability of the organ increases which may allow labor to occur. Infections in the kidney (pyelonephritis), appendicitis, and even severe gastroenteritis (flu) may initiate premature labor. Extra fluid in the uterus (polyhydramnios) or a multiple gestation (twins, triplets) will also cause the uterus to increase its volume too quickly and may lead to preterm labor.

Tocolysis is the process of stopping labor. This may be done in simple cases by getting the pregnant patient off her feet and at strict bed rest. The next step is to hydrate the patient which is usually done with intravenous fluids. Sedation may be used to decrease the uterine irritability. Certain medications known as beta mimetics have the ability to decrease the contractility of the uterine musculature. All of these modalities have been used with some success to prevent the birth of the very immature neonate.

Even more basic than these types of care is the notion of early prenatal care of the pregnant patient. This care is cost effective and has the ability to diagnose and treat many conditions associated with pregnancy before they become major problems.

Another of the many uses of ultrasound is to assess the physical characteristics of the developing fetus. It is well known what the normal anatomy is at the various stages of development of the fetus. Variations from the normal may be detected and intervention undertaken.

Some types of defects which are detected antenatally are important to know so that appropriate care is ready at the time of the birth. We have been able to detect and prepare for such anomalies as as hydrocephaly, certain heart deformities, and in one case in my own practice, a bowel obstruction. Happily, most of these types of problems are those which can be corrected by surgical techniques.

Of course, there are some abnormalities that are detected which are not correctable. The knowledge that here is a problem may allow the patient to prepare for the eventuality of the disease. The couple may be able to gain a great deal of information to help them cope with the impending birth.

One dramatic story involves a couple who underwent an ultrasound evaluation because the uterus had not grown appropriately. The examination revealed that the fetal heart had a structural defect that was uniformly fatal and could not be corrected by surgery. This patient was sent to Loma Linda University Medical Center while she was still pregnant. Next term, an infant heart became available. The infant was delivered by cesarean section and a heart transplant performed on the newborn baby. The child is doing well to this day.

At my hospital, we are even employing the use of the ultrasound in the evaluation of the physiologic functioning of the infant. By doing a standard nonstress test, the examiner is able to evaluate the status of the fetal heart. By measuring the amount of amniotic fluid present, the function of the placenta is determined. By adding the study of the resistance to blood flow in the umbilical vessels, one can determine quite accurately how well the infant is doing. New research has suggested that one can even assess the amount of oxygen in the vessels of the fetal head. By judicious use of these exciting new technological innovations, the rate of stillbirths has decreased by 200 percent at our institution.

I give the details of these clinical situations as a background for my remarks on S. 1912. It is imperative to understand the clinical milieu in which medicine is practiced in 1990, for it is far different from the 1973 environment in which Roe was decided.

I begin my discussion of the bill by noting the unusually simple even deceptive language in which it is written. This simplicity may lead to further confusion, particularly when clinical judgments need to be made, for there are no definitions given. For example, when one

begins to assess the viability of an infant, it is much more complex than in the past. Consequently, when the United States Supreme Court speaks of fetal viability as when the infant is "potentially able to live outside the mother's womb, albeit with artificial air," that definition is much broader now than in the past.

I speak also of the physician's concern on being able to make a judgment about "meaningful life." What may be meaningful to me may not coincide with the views of another. There is no scientific test to measure this particular parameter.

The bill does not allow for the use of informed consent. I am deeply concerned about the possibility of circumventing the informed consent rules. That abortion should be different from other surgical procedures is not apparent to this clinician. Even if it could be construed that informed consent may make the patient think twice about the procedure, I argue that this is appropriate from the medical standpoint in that the patient needs to be completely informed. She also ought to know the potential adverse medical effects of this procedure just as she ought to know those facts about any other proposed procedure.

S. 1912 prohibits parental notification. In terms of a minor, the case for informed consent which would include the involvement of a parent could be made even more strongly. No other procedures (except life saving ones) can be performed on a minor without parental consent. For medical reasons, the parent ought to be aware of the potential for adverse outcomes of this procedure as for any other. That the procedure has such an emotional component would argue more strongly in favor of this doctrine as well. A parent, even an upset parent, would in most cases have the well-being of his or her child in the forefront at all times.

Further, I am concerned about the physician. With the increasingly litigious nature of our society particularly towards the obstetrician-gynecologist, I have grave concerns for the legal protection of the doctor if informed consent is not obtained. The standard argument in professional liability cases is that the patient is not as informed as he or she should have been. Without this protection, the doctor would stand in a very vulnerable position.

The bill does not specify that the procedure must be done by physicians. In fact, it does not even suggest that the individuals performing such procedures even be trained or licensed. I am very aware of the abilities of many non-physician care providers. I have worked in my own office with Certified Nurse Midwives who are excellent and well trained. Still, my experience would suggest to me that only physicians, by virtue of their professional training, are qualified to perform suction curettrages of the uterus. This surgical procedure carries with it the potential for many serious complications.

One of the most serious is significant hemorrhage. These hemorrhages can be life-threatening. If not treated vigorously and

immediately, a life can be lost. If standard treatments are not effective to control the hemorrhage, the operator should be qualified to perform an emergency, life-saving, hysterectomy. This is clearly beyond the scope of all except those physicians who have been trained to do such procedures. Even if there is help "nearby," the rapidity with which blood can be lost can be fatal. In my own mind, I wonder whether it should be mandatory that the operator be trained in gynecologic surgery.

Sepsis or infection can be insidious, and can lead to a life of chronic infection and pelvic pain. In some instances, it can lead to infertility or sterility and, in extreme cases, even death. While many kinds of practitioners can be and are trained in sterile technique, only those who frequent an operating suite are facile in its use.

Perforation of the uterus is a recognized complication of any procedure where an instrument is placed in the uterine cavity. Early recognition of the problem with prompt evaluation including exploratory surgery can be fertility saving, if not life saving. The operator ought to be capable of detecting and caring for this serious kind of complication.

When a dilatation and curettage (or D and C) is done, the surgeon must be especially careful to remove as much tissue as possible, but not to remove the lining tissue of the uterus. This lining tissue is called the endometrium and is extremely important. In the pregnant uterus, the tissues are much softer. Therefore, it is much easier to remove more than the desired amount of tissue. If this were to occur, there is the possibility for the back (posterior) wall of the uterus to adhere to the front (anterior) wall and scar together. These scars called uterine synechiae cause the uterine cavity to be closed in effect. This condition is called Aherman's syndrome. If it were to occur, there is a great possibility that the patient will be unable to bear children in the future.

The proposed legislation would not allow for the keeping of medical records. In addition to having a trained professional perform the procedure and obtain informed consent, it is extremely important for the physician to have access to a pathology report of the tissue removed. Of course, the tissue identified will most likely be "products of conception," but there are conditions that need to be identified. Occasionally, there may be an unusual deterioration of the placenta which is called a hydatidiform mole. If this is not recognized, in addition to the increased possibility of hemorrhage, the patient may develop complications from this condition. If the tissue begins to invade the muscular layer of the uterus (myometrium), it may become chorioadenoma destruens. If left untreated, this may develop into a condition known as choriocarcinoma which is a malignant disease. This particular type of cancer is well treated and the outcome is excellent today. But before any treatment can be instituted, a diagnosis must be made.

At certain times, a patient may be pregnant, but not in the uterus. This is called an ectopic pregnancy. The pregnancy is usually found in the fallopian tube. When this occurs, the uterus continues to react as if it were pregnant. It grows, is soft, and may appear to be pregnant. A cardinal rule after a D and C on a pregnant uterus is to read the pathology report. One must see the words "chorionic villi" on the report. These are the small anchoring processes of the placenta which allow the placenta to become attached to the uterine wall. If these villi are not seen, but there is an exaggerated response of the uterine lining tissue, the Arias-Stella phenomenon has occurred. This indicates the possibility of an ectopic pregnancy and the patient should be notified and evaluated at once. A ruptured tubal pregnancy is a medical emergency and if not treated will always lead to the death of the patient by internal hemorrhage.

The bill does not allow for accreditation of institutions in which such procedures are performed. As a member of a hospital medical staff, I am pleased to tell you that I practice at a hospital that is accredited by the Joint Commission on Accreditation of Healthcare Organizations. In order to obtain such accreditation, there is a large list of items which must be in compliance with strict JCAHO standards. The purpose of these regulations is to assure that the care provided at the facility is safe and of good quality. Inasmuch as suction curettages are surgical procedures which have to potential of having some of the complications previously mentioned, it makes sense to require any facility providing such procedures to conform to a certain agreed upon standard. If no such standards are in place, then there is no apparent mechanism to assure that the care received there is of sufficient quality.

The language of the bill suggests an arbitrary division of a pregnancy into semesters: one before fetal viability (not defined) and one after. The dividing of a pregnancy into trimesters is a clinical division, not a legal one. This is done because there are certain biologic characteristics which are typical of certain gestational ages. For example, the bulk of the development of most of the organs of the body has taken place by the end of the first trimester. In the third trimester, fetal viability is assured with appropriate care. It makes no sense from a medical standpoint to redefine gestation as is proposed.

No concern is expressed in the bill for those health care professionals who have objections to performing abortions. In an era where access to health care is a major concern to all, I have unusually deep concerns that the proposed legislation imposes on all physicians, nurses, and other health care personnels the necessity of performing abortions. There is no allowance made for those of us with deep philosophic or moral convictions about the propriety of abortions to be able to opt out of having to participate in such procedures. I am currently seeing any patient who comes to my office irrespective of her ability to pay. I have always seen and plan to continue to see Medicare patients (I am a participating physician) and Medicaid patients. In S. 1912, I would not be protected legally from having to do procedures that I find to be morally offensive. If I am compelled

to perform such procedures as abortions, I shall have to stop practicing medicine. The reason is not just that I find the procedure to be inappropriate personally, but more importantly, the legislation has interposed itself between my patient and me. It tells me how to practice medicine without knowing anything about the clinical situation. Not only does this apply to obstetrician - gynecologists, but theoretically, it could apply to any physician who practices at a hospital which receives federal funding. With such a shortage of specialists in my field, especially in the rural areas, I would express serious concerns about the potential availability of care in certain geographic regions.

Finally, I have concerns about the Congress of the United States deciding what diseases, conditions, or procedures that will be paid for and which ones will not. I am worried that if there is not sufficient imput from many sources that inappropriate decisions will be made. How we should make allocation decisions is an important subject worthy of serious debate. I would feel that if the Congress were to decide which procedures would be funded that the list might very appropriately begin with some procedures other than abortion.

It seems to me that there are many serious shortcomings in the proposed legislation from a medical standpoint. I feel that there are more questions raised than answered. I continue to feel that this bill would place inappropriate barriers between patients and physicians. This is the antithesis of what is needed in health care in the United States today.

Senator METZENBAUM. Before we turn to our last witness on this panel, I am going to do something somewhat unusual in these hearings. At the conclusion of the next witness' testimony, I am going to give the witnesses themselves an opportunity to have an exchange with each other, publicly, of course, very briefly because I think that you are the professionals in this area; you are the ones who are far more knowledgeable than we who sit here at the table writing legislation. That might be informative for us on the committee.

Before doing so, I am pleased to have join us this morning both Senator Simon and Senator Adams. I don't know if they have any particular opening statements; I did not make much of an opening statement, but if you have one, we will certainly be glad to hear from you.

Senator ADAMS. No; I will put my opening statement into the record, Senator Metzenbaum, and I just appreciate the opportunity of being here with you this morning. I am very interested in the information we are receiving.

Senator METZENBAUM. We are very pleased that both of you are with us, and your statements will be included immediately after my own.

[The prepared opening statement of Senator Adams follows:]

OPENING STATEMENT OF SENATOR ADAMS

I regret that it became necessary to join Senator Cranston to introduce S. 1912, the Freedom of Choice Act. I had hoped that by 1990 we would be long past the debate in this country regarding the fundamental right of women to choose whether to have an abortion. Apparently we are not. Last week, we witnessed actions in legislatures in Idaho and Guam which, if allowed to stand, will severely and tragically restrict a woman's right to make decisions regarding her own body.

In 1973, nearly 20 years ago, the Supreme Court held in *Roe v. Wade* that the Constitution protects a woman's decision regarding whether to terminate a pregnancy. As part of that decision, the Supreme Court established the fetal viability stage as the appropriate point to trigger any regulatory action by the State. The Court held that following viability, the State's interest permitted it to regulate and even prohibit abortion except when necessary for the preservation of the life or health of the mother.

S. 1912 codifies the *Roe v. Wade* decision by establishing the regulatory powers of the state. It is made necessary by the recent Supreme Court decision on July 3rd of last year in *Webster v. Reproductive Health Services.* While this decision did not overturn *Roe v. Wade*, the Court indicated its willingness to review individual state regulatory approaches to abortion.

We need to recognize that the result of the 1989 *Webster* decision may very well be chaos. And we need to recognize that individual state actions such as those in Idaho and Guam will lead to an incoherent policy in this Nation regarding a woman's right to make decisions regarding the health and well-being of her own body. An inequitable approach to this basic freedom is unacceptable to this Senator, and it is unacceptable to a majority of Americans.

We cannot go back to the battles of the 1960s—to a time of butchers, back alley abortions, and unwanted pregnancies. We moved past that in 1973 with the *Roe v. Wade* decision. We must now move forward to another pressing agenda: How to feed, house, clothe, and educate all of the children of American—rich and poor alike—who are here and so desperately need our help and attention.

It was recently said that President Bush follows public opinion closely before determining public policy. Well, I hope the President is listening to the American people on this one. The majority of Americans want to preserve the right of an individual woman to make her own decision on whether to terminate a pregnancy. They do not want the government making this decision for them.

S. 1912 is not a pro abortion bill and it not an anti-abortion bill. It is a bill that preserves the most fundamental freedoms upon which our Nation was founded—the freedom to believe as one likes, to have privacy over one's person, and to exercise those fundamental rights without government interference.

I hope we go forward today with a renewed commitment to reaffirm the *Roe v. Wade* decision. It is time to go forward with an agenda for the 1990s—not go backward to the worn out agenda of the 1960s. I want to be able to spend my time passing child care, parental leave, Head Start, Smart Start, Clean Air, and Health care legislation.

That's where the real agenda for the future is, Mr. Chairman, and it's time to act on it.

Senator METZENBAUM. Senator Simon.

Senator SIMON. I have no opening statement, Mr. Chairman. I join in thanking you.

Unfortunately, we have a markup in the Foreign Relations Committee, so I am going to be back and forth, but I really appreciate the witnesses being here.

Senator METZENBAUM. Thank you very much for being here.

Dr. Glasow, we are happy to hear from you.

Dr. GLASOW. Thank you, Senator.

Mr. Chairman, I am Richard D. Glasow, Ph.D., Education Director of the National Right to Life Committee.

The National Right to Life Committee is the Nation's major pro-life organization. We represent about 3,000 local pro-life chapters. We are advocates for those innocent human beings whose right to life is threatened by abortion, infanticide or euthanasia. The National Right to Life Committee and its affiliates take no position on contraception.

Authorities agree that only a small percentage of all abortions currently performed in the United States are because of rape and incest, fetal disability or physical life or health of the mother.

I shall cite evidence from a study of the reasons that women obtain abortions conducted by a pro-abortion organization, statistics about the characteristics of women who obtained abortions, testimony by a leading pro-abortion advocate, and Federal and State Medicaid funding statistics.

Our analysis of the data from a survey of 1,900 women seeking abortions conducted by a leading pro-abortion organization confirms the long-term pro-life assertion that over 94 percent of abor-

tions are performed for social reasons and not for rape, incest, genetic abnormality of the unborn child or protection of the mother's health or life.

This survey is of special interest because of the impeccable pro-abortion credentials of the researchers from the Alan Guttmacher Institute, Planned Parenthood's research arm. With the active assistance of abortion providers, the AGI staff conducted a survey at 30 abortion facilities across the country from November 1987 through March 1988 and published the results in the July/August 1988 issue of it's magazine, *Family Planning Perspectives.*

One significant finding was that one percent of the women in the study indicated they sought the abortion because they were "a victim of rape or incest".

In analyzing the incidence of abortion for "health" reasons and genetic abnormality of the unborn child, it is important to separate the number of women who based their decision on information from a physician and which did not. Less than one percent of the women in the survey indicated they sought the abortion because a doctor "had told them that their health condition would be made worse by being pregnant". One percent of the women surveyed sought abortion because "a physician had advised them that the fetus had a defect or was abnormal".

Let's look at some other sources of evidence. Two statistics about the incidence of abortion also indicates how abortion is being used as a method of birth control. According to an article published by the Alan Guttmacher Institute, 42.9 percent of the abortions in 1987 were repeat abortions, which is defined as a woman's second, third or fourth or more abortion. Moreover, the article reported that 49 percent of the women seeking abortions in 1987 were not using any contraceptive method during the month in which they became pregnant. The percentage of the women who were not using a contraceptive on the occasion that they became pregnant is probably much higher.

A statement by a leading pro-abortion advocate offers additional evidence that over 94 percent of the abortions are being performed for social reasons. In October 1981, a leading supporter of *Roe v. Wade*, Dr. Irving Cushner, a former official of the Department of Health, Education and Welfare at that time, and member of the board of directors of the Alan Guttmacher Institute, testified before the U.S. Senate Judiciary Committee that "something on the order of 2 percent of all abortions in this country are done for some clinically identifiable entity—physical health, amniocentesis, and identified genetic disease or something of that kind."

He went on to say "the overwhelming majority of abortions in this country are performed on women who for various reasons do not wish to be pregnant at this time. Some of them do not wish to have children ever, but the overwhelming majority do not wish to be pregnant at this particular time. Their reasons are a mixture of social, educational, or whatever."

Another indicator of how few abortions are being performed for other than the "hard-case" reasons may be derived from records of Federal and State Government funding of abortion. While this data on Medicaid-eligible women's abortions may not precisely reflect national trends, the statistics of Federal funding under the Hyde

amendment and State Government funding in 1985 in Minnesota, Pennsylvania, Iowa, Virginia and Wisconsin, and in Wyoming in 1980 and 1981, give a strong indication that only a tiny percentage of abortions are performed for hard-case reasons.

In summary, this evidence from the study of the reasons that women obtain abortions conducted by a pro-abortion organization, statistics about the characteristics of women who obtained abortions, testimony by a leading pro-abortion advocate, and Federal and State Medicaid funding statistics clearly indicate that only a small percentage of all abortions currently performed in the United States are because of rape and incest, fetal disability, or physical life or health of the mother.

Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much.

[The prepared statement of Dr. Glasow follows:]

TESTIMONY OF RICHARD D. GLASOW, PH.D., NATIONAL RIGHT TO LIFE COMM.

INTRODUCTION

Mr. Chairman, I am Richard D. Glasow, Ph.D., Education Director of the National Right to Life Committee (NRLC).

The National Right to Life Committee is the nation's major pro-life organization. We represent about 3,000 local pro-life chapters. We are advocates for those innocent human beings whose right to life is threatened by abortion, infanticide, or euthanasia. The National Right to Life Committee and its affiliates take no position on contraception.

Authorities agree that only a small percentage of all abortions currently performed in the United States are because of rape and incest, fetal disability, or physical life or health of the mother.

I shall cite evidence from a study of the reasons that women obtain abortions conducted by a pro-abortion organization, statistics about the characteristics of women who obtained abortions, testimony by a leading pro-abortion advocate, and federal and state Medicaid-funding statistics.

STUDY BY PRO-ABORTION GROUP

CONFIRMS WOMEN ABORT FOR SOCIAL, NOT HEALTH REASONS

Our analysis of the data from a survey of 1,900 women seeking abortions conducted by a leading pro-abortion organization confirms the long-time pro-life assertion that over ninety-four percent of abortions are performed for social

reasons, and not for rape, incest, genetic abnormality of the unborn child, or protection of the mother's health or life.[1]

This survey is of special interest because of the impeccable pro-abortion credentials of the researchers from the Alan Guttmacher Institute (AGI), Planned Parenthood's research arm. With the active assistance of abortion providers, the AGI staff conducted the study at 38 abortion facilities across the country from November 1987 through March 1988 and published the results in the July/August 1988 issue of AGI's magazine, Family Planning Perspectives.

The women seeking abortions received multiple-choice questionnaire and asked to indicate, first their "most important" reason contributing to their abortion decision, and then list other reasons that also had a bearing. These findings are summarized in table in Appendix A. In order to avoid any claim that our analysis was biased in a pro-life direction, we used the higher percentage.

One significant finding was that 1% of the women in the study indicated they sought the abortion because they were a "victim of rape or incest."[2]

In analyzing the incidence of abortion for "health" reasons

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[1]Aida Torres and Jacqueline Darroch Forrest, "Why Do Women Have Abortions," Family Planning Perspectives, vol. 20, no. 4 (July/August 1988), pp. 169-176.

[2]Ibid., Table 1, p. 170.

and genetic abnormality of the unborn child, it is important to separate the number of women who based their decision on information from a physician and which did not. Less than 4% of women in the survey indicated that they sought the abortion because a doctor "had told them that their [health] condition would be made worse by being pregnant."[3] One percent of the women surveyed sought abortion because "a physician had advised them that the fetus had a defect or was abnormal."[4]

Among the most important findings, observed Aida Torres and Jacqueline D. Forrest, the two AGI staffers who wrote the article, were the fact that "[t]hree-quarters [of the women surveyed] said that having a baby would interfere with work, school or other responsibilities, about two-thirds said they

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[3]"In all, 53 percent of those having an abortion because of a health problem said that a doctor had told them that their condition would be made worse by being pregnant," stated the AGI article.

Therefore, less than 4% (computed as .53 times .07 = .037--or 3.7%) of the 1,900 women surveyed gave a personal health condition based on advice from a physician as a hard case reason for abortion. The percentage would be even lower if we used the figure for the "most important reason."

[4]Thirteen percent of all of the 1,900 women surveyed stated that a possible health problem of the fetus contributed to their decision to abort, and according to additional information provided in the text of the AGI article, of that thirteen percent, only eight percent said "that a physician had advised them that the fetus had a defect or was abnormal," a justification that most members of the public would consider as a "hard case" reason for their abortion.

Therefore, only 1% (computed as .08 times .13 = .01--or 1%) of the 1,900 women surveyed gave fetal abnormality identified by a physician as a reason for abortion. The percentage would be even lower if we used the figure for the "most important reason."

could not afford to have a child, and half said they did not want to be a single parent or had relationship problems." These are all "social" or "economic" reasons for obtaining an abortion.

Although this Family Planning Perspective article offers the best information available, several major methodological deficiencies prevent it from being the definitive study. While the media accepts articles from the Guttmacher Institute's magazine as gospel, the publication is an in-house publicity organ, and articles in it are not checked for objectivity and accuracy by independent outside referees in the same way as regular scientific papers. Moreover, the conditions under which the poll was undertaken forced the authors to make some compromises that degraded the quality of their results. Despite these drawbacks, the survey does offer some information on a virtually unknown area.

Three Important Implications

The Guttmacher Institute study has three important implications for the continuing policy debate on abortion.

First, the study offers valuable insights into the psychological and financial problems confronting women with crisis pregnancies. The respondents said they felt isolated, and in some cases even pressured by their family and husband or "partner" to abort.

Second, the study is important because it begins to fill in a major gap in information about the psychological, social, and

economic reasons that women choose abortion. Information has been scarce on this vitally important topic because pro-abortion advocates have successfully used Roe v. Wade to challenge reporting requirements in the courts. Citing precedents in the landmark abortion cases, judges have stuck down state laws which required women to be questioned about their reasons for seeking abortions. The courts held that such requirements could violate the confidentiality of the abortion decision and were not related to the state's interest in protecting maternal health.[5]

The AGI's survey of women seeking abortions can also have an impact on the policy debate over unrestricted abortion by heightening public awareness of how women use abortion for social reasons, indeed, as "birth control." Public opinion polls have consistently shown that the majority of the American public does not support abortion for "social" or "convenience"reasons.[6]

Interestingly, by publishing this article, the leaders for the abortion industry now has done an about-face by collecting the information that they have been gone to court to hide before. Why the change of policy now? Perhaps, they hope to influence

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[5]Lynn D. Wardle, "Reporting and Record Keeping Requirements," Chapter IV, **The Abortion Privacy Doctrine: A Compendium and Critique of Federal Court Abortion Cases**, (Buffalo, N.Y.: William S. Hein & Co, Inc., 1980) pp. 51-59.

[6]For example, Balz, "Poll Finds Majority in U.S. Back Abortion Rights," **Washington Post**, Oct. 7, 1989. Apple, "Limits on Abortion Seem Less Likely," **New York Times**, Sept. 29, 1989, p A1, col. 1. Baxter, "Survey Shows South Is Torn Over Abortion," **Atlanta Journal & Constitution**, July 28, 1989, p. 1.

the policy debate.

Apparently looking ahead to the possibility Roe v. Wade may be overturned, the Guttmacher Institute researchers asserted in the closing section of their report that "[f]indings from this survey indicate that eliminating (or even substantially reducing the number of) abortions once women have become unintentionally pregnant will be very difficult, if not impossible, because the reasons women turn to abortion are so numerous and varied." AGI's overly simplistic and profoundly fatalistic approach is an attempt to divert attention from the fact that the majority of women are using abortion as a method of birth control.

Other Sources of Evidence

Two statistics about the incidence of abortion also indicate how abortion is being used as a method of birth control. According to an article published by the Alan Guttmacher Institute, 42.9% of the abortions in 1987 were repeat abortions, which is defined as a woman's second, third, or fourth (or more abortion).[7] Moreover, the article reported that 49% of the women seeking abortions in 1987 were not using any contraceptive method during the month in which they became pregnant.[8] The percentage

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[7]Stanley K. Henshaw and Jane Silverman, "The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients," Family Planning Perspectives, vol. 20, no. 4 (July/August 1988), p. 159.

[8]Ibid., p. 165.

of the women who were not using a contraceptive on the occasion that they became pregnant is probably much higher.

A statement by a leading pro-abortion advocate offers additional evidence that over 94% of abortions were being performed for social reasons. In October 1981, a leading supporter of Roe, Dr. Irving Cushner, a former official of the Department of Health, Education and Welfare and member of the board of directors of the Alan Guttmacher Institute, testified before the U.S. Senate Judiciary Committee that "something on the order of 2 percent of all abortions in this country are done for some clinically identifiable entity--physical health, amniocentesis, and identified genetic disease or something of that kind." He went on to say that "The overwhelming majority of abortions in this country are performed on women who for various reasons do not which to be pregnant at this time. Some of them do not wish to have children ever, but the overwhelming majority do not wish to be pregnant at this particular time. Their reasons are a mixture of social, educational, or whatever."[9]

Records of Medicaid Funding Indicate Reasons for Abortions

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[9]"Statement of Irvin M. Cushner, M.D., M.P.H., University of California, School of Medicine and School of Public Health, Los Angeles, Calif.," October 14, 1981, U.S. Senate, Committee on the Judiciary, Hearings Before the Subcommittee on the Constitution, Constitutional Amendments Relating to Abortion, 97th Cong., 1st Sess., Serial J-97-62, volume 1, p. 158.

Another indicator of how few abortions are being performed for other than "hard-case" reasons may be derived from records of federal and state government funding for abortion. While this data on Medicaid-eligible women's abortions may not precisely reflect national trends, the statistics give a strong indication that only a tiny percentage of abortions are performed for "hard-case" reasons.

Federal Medicaid Funding

Under the Hyde Amendment, federal Medicaid funding has long been limited to those abortions necessary to preserve the life of the mother, thus reducing the number of abortions funded from over 300,000 annually before 1976[10] to 75 in FY 1987.[11] However, during fiscal Year 1979, federal Medicaid funds were provided for

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[10]Alan Guttmacher Institute, Abortion and the Poor: Private Morality, Public Responsibility (New York, 1979), p. 13.

[11] The most recent statistics are included in Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations for 1990: Hearings Before the Subcomm. on the Departments of Labor, Health and Human Services, Education, and Related Agencies of the House Comm. on Appropriations, 101st Cong., 1st Sess., pt. 2, at 148-54 (1989) (Health Care Financing Administration report on Abortions).

Statistics that provide details for Fiscal Years 1978 through 1983 are included in Bureau of Program Operations, Health Care Financing Administration, Dep't of Health and Human Services, "Report on Medicaid Financed Abortions October 1, 1982 - September 30, 1983" (Dec. 1983).

Note: Although a table in Gold & Guardado, "Public Funding of Family Planning, Sterilization and Abortion Services, 1987," Family Planning Perspectives, vol. 20, no. 5 (September/October 1988), pp. 228, 232 (Table 3) lists 322 federally funded abortions to preserve the life of the mother for Fiscal Year 1987, many of these were later determined not to be necessary for the life of the mother, and only 75 were actually federally funded.

abortions for a broader range of circumstances: life of the mother, prevention of severe and longlasting physical health damage to the mother, and rape and incest.[12] During that year only 3,675 abortions were funded.[13]

State Medicaid Funding

Statistics from states restricting government funding of abortions to limited "hard case" circumstances indicate that very few abortions are performed for those reasons.[14] This is evident by a comparison of the total number of abortions performed in each state to the total number of abortions funded for life of the mother and so-called "hard-case" reasons (rape, incest, disability of the child, or severe health damage to the mother).

Articles published by the Alan Guttmacher Institute list the expenditures for--and the number of--state-funded abortions in each state and the number of reported abortions in each state and

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[12] See Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations for 1990: Hearings Before the Subcomm. on the Departments of Labor, Health and Human Services, Education, and Related Agencies of the House Comm. on Appropriations, 101st Cong., 1st Sess., pt. 2, at 148-50 (1989) (Health Care Financing Administration report on Abortions).

[13] See Bureau of Program Operations, Health Care Financing Administration, Dep't of Health and Human Services, "Report on Medicaid Financed Abortions October 1, 1982 - September 30, 1983" (Dec. 1983).

[14] See generally, Rachel Benson Gold and Sandra Guardado, "Public Funding of Family Planning, Sterilization and Abortion Services, 1987," Family Planning Perspectives, vol. 20, no. 5, (September/October 1988), pp. 228, Table 3 on 232, 233.

the rate of abortion per 1,000 women for 1982, 1984 and 1985.[15]

Let's examine several examples.

In 1985, Minnesota and Pennsylvania funded abortions for reasons of rape, incest and preservation of the mother's life. That year, although 16,850 abortions took place in Minnesota and 57,370 abortions took place in Pennsylvania, none of these met funding requirements. That is, no abortions performed on Medicaid-eligible women fell into these "hard cases" categories.[16]

Iowa and Virginia fund abortions only for unborn disability, rape, incest and preservation of the mother's life. In 1985, although 9,930 abortions took place in Iowa and 34,180 abortions took place in Virginia, only 9 abortions in Iowa and 43 abortions in Virginia were state-funded.[17]

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[15]Although Medicaid-funding statistics more recent than 1985 are available, data for Fiscal Year 1985 are used here because no statistics for the overall number of abortions performed in each state after Fiscal Year 1985 are yet available. Statistics are provided in Rachel Benson Gold and Jennifer Macias, "Public Funding of Family Planning, Sterilization and Abortion Services, 1985" **Family Planning Perspectives**, vol. 18, no. 6 (November/December 1986), pp. 259, 263. Stanley K. Henshaw, Jacqueline Darroch Forrest, and Jennifer Van Vort, "Abortion Services in the United States, 1984 and 1985," **Family Planning Perspectives**, vol. 19, no. 2 (March/April 1987), Table 3, p. 65.

[16]Stanley K. Henshaw, Jacqueline Darroch Forrest, and Jennifer Van Vort, "Abortion Services in the United States, 1984 and 1985," **Family Planning Perspectives**, vol. 19, no. 2 (March/April 1987), Table 3, p. 65. Due to a loophole in its rape reporting law, Pennsylvania funded 478 abortions in 1987; this loophole was virtually closed by the Pennsylvania Abortion Control Act signed by the governor in April 1988.

[17]Ibid.

Wisconsin funds abortions for "severe health damage," rape, incest and preservation of mother's life. Although 17,830 abortions were performed in Wisconsin in 1985, none qualified for state government funding.[18]

The AGI articles did not report data on state-government funded abortions in Wyoming in 1985; therefore, a comparison is not possible for that year. However, data is available for 1980 and 1981. One thousand-seventy abortions were performed in Wyoming in 1980 and 950 in 1981; none were state-funded either year.[19]

SUMMARY

In summary, this evidence from a study of the reasons that women obtain abortions conducted by a pro-abortion organization, statistics about the characteristics of women who obtained abortions, testimony by a leading pro-abortion advocate, and federal and state Medicaid-funding statistics clearly indicates that only a small percentage of all abortions currently performed in the United States are because of rape and incest, fetal disability, or physical life or health of the mother.

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[18]Stanley K. Henshaw, Jacqueline Darroch Forrest, and Jennifer Van Vort, "Abortion Services in the United States, 1984 and 1985," **Family Planning Perspectives**, vol. 19, no. 2 (March/April 1987), Table 3, p. 65. Rachel Benson Gold and Jennifer Macias, "Public Funding of Family Planning, Sterilization and Abortion Services, 1985" **Family Planning Perspectives**, vol. 18, no. 6 (November/December 1986), pp. 263, 264.

[19] Stanley K. Henshaw, Jacqueline Darroch Forrest and Ellen Blaine, "Abortion Services in the United States, 1981 and 1982," **Family Planning Perspectives**, vol. 16, no. 3 (May/June 1984), pp. 119, 120 (Table 1). Rachel Benson Gold, "Publicly Funded Abortions in FY 1980 and FY 1981," **Family Planning Perspectives**, vol. 14, no. 4 (July/August 1982), pp. 204, 205.

APPENDIX A

The answers to the questions posed in the survey are summarized in the following table based on Table 1 in "Why Do Women Have Abortions," *Family Planning Perspectives*, vol. 20, no. 4 (July/August 1988), p. 170. Footnotes in the original table are omitted.

Reasons Women Obtain Abortions

Reason	Percentage Who Said This Reason Was "Most Important	Percentage Who Said This Reason Influenced Decision In Any Way
Woman is concerned about how having a baby could change her life	16%	76%
Woman can't afford baby now	21%	68%
Woman has problems with relationship or wants to avoid single parenthood	12%	51%
Woman is unready for responsibility	21%	31%
Woman doesn't want others to know she has had sex or is pregnant	1%	31%
Woman is not mature enough, or is too young to have a child	11%	30%
Woman has all the children she wanted, or has all grown-up children	8%	26%
Husband or partner wants woman to have abortion	1%	23%
Fetus has possible health problem	3%	13%#
Woman has health problem	3%	7%*
Woman's parents want her to have abortion	less than .5%	7%
Woman was victim of rape or incest	1%	1%
Other	3%	6%

The following footnotes to the table above explain how the percentages for "life of the mother" and "genetic abnormality" described in the text above were calculated.

#The actual number of abortions for "genetic abnormality," a situation that most members of the public would regard as a "hard case," is actually significantly smaller than the 13% listed here because of the broad category that AGI used in constructing this table.

Thirteen percent of all of the 1,900 women surveyed stated that a possible health problem of the fetus contributed to their decision to abort, and according to additional information provided in the text of the AGI article, of that thirteen percent, only eight percent said "that a physician had advised them that the fetus had a defect or was abnormal," a justification that most members of the public would consider as a "hard case" reason for their abortion.

Therefore, only 1% (computed as .08 times .13 = .01—or 1%) of the 1,900 women surveyed gave fetal abnormality as a reason for abortion. The percentage would be even lower if we used the figure for the "most important reason."

*The actual number of abortions sought for what most members of the public would regard as a "hard case" of "endangering the life or health of the mother" is actually significantly smaller than the 7% listed in the table because of the broad category that AGI used in constructing this table.

"In all, 53 percent of those having an abortion because of a health problem said that a doctor had told them that their condition would be made worse by being pregnant," stated the AGI article.

Therefore, less than 4% (computed as .53 times .07 = .037—or 3.7%) of the 1,900 women surveyed gave a personal health condition as a hard case reason for abortion. The percentage would be even lower if we used the figure for the "most important reason."

To accompany testimony of Richard D. Glasow, Ph.D.
National Right to Life Committee

Senator METZENBAUM. As the chair indicated, if any member of the panel has a question which they wish to pose to another member of the panel, the chair would recognize that at this point.

Dr. FORREST. I certainly would like to make a comment, other than I wish I had known what Dr. Glasow was going to be saying because I could have saved some of my time since he was summarizing much of the information that we published over the past few years.

I think that there are three major points that I'd like to make in discussion of some of those comments. One is that he is characterizing the organization for which I work as well as much of my own work as being done by pro-abortion organizations or pro-abortion people, and if anything, as I tried to point out in my testimony, the point I am trying to make as an individual, as a researcher and as an organization is that we need to be working as a country to prevent abortion by preventing the need for abortion, the unintended pregnancies that occur in this country.

Legalizing abortion, keeping it legal, not keeping it legal, does not determine whether women have an abortion; it determines the conditions under which they have it. What is going to make the difference in decreasing abortion, which I think there is no doubt that everybody in the country would like to do, is decreasing unintended pregnancy.

Another bill that your committee has reported out, the Title X Family Planning Services bill, is very important to achieve that and provide contraceptive services, increase contraceptive research in this country. Congress needs to move on that; that would make a very important contribution to decreasing abortion

Senator METZENBAUM. Thank you very much.

Does anyone else wish to add or comment? [Pause.]

If not, Dr. Glasow, your testimony states that the Right to Life Committee does not take a position on contraception. How would you propose that women avoid unintended pregnancy, and would you allow women to use birth control pills or the I.U.D. or this new French procedure that has been so much talked about?

Dr. GLASOW. Mr. Chairman, I'll take the last point first. We are absolutely opposed to the use of the abortion pill, RU-46 in the United States or anywhere in the world. It is definitely an abortifacient; it is not a contraceptive. Our position has been very clear in previous hearings, in discussions in the newspaper and so forth.

As I said in the beginning of my testimony, we take no position on contraception. Members of our organization run the gamut on that issue. We are concerned with the protection of innocent unborn life from the moment of fertilization onward.

Senator METZENBAUM. But Dr. Glasow, are you not just leaving a void there for millions of American women if you take a position against abortion and you don't say to them what they can do or should do in the event they cannot afford to have a child, in the event they actually do not wish to have a child, for any one of a number of reasons—is there not some sense of responsibility that the National Right to Life Committee has? You can't just leave the problem hanging out there as I see it, without addressing yourself to it.

Dr. GLASOW. Well, I think there are two answers to that question, Mr. Chairman. In all deference, I think that we are entitled to our agenda, as it were. We are entitled to the public policy objectives that our members feel are appropriate. We are interested in saving the lives of 1.5 million Americans who die through abortion every year. And I think that is a very worthwhile goal that we think the public should support, and we urge them to back our legislative initiatives.

We are also very concerned about the women who have problem pregnancies. It is the Right to Life movement that has established problem pregnancy centers across the United States. We believe that there are more problem pregnancy centers established than there are abortion facilities. They are done out of people's pockets. They receive virtually no Government money. They are run by volunteers. I think that is indicative of our real concern for both the mother and the child.

Third, as I indicated in my testimony, abortion is being used as a method of birth control. Over half the women in this country do not use contraceptives on the occasion that they become pregnant. I think there is a very strong public consensus against abortion being used as a method of birth control, and we are eager to restrict abortion for that purpose.

Senator METZENBAUM. Dr. Nelson, I wasn't sure that I quite understood what you said about your possibly being forced to leave the practice and the reason for that. Would you be good enough to repeat that for me?

Dr. NELSON. Yes, Mr. Chairman, thank you very much.

I am not convinced that S. 1912 allows for a person who chooses not to perform an abortion to be able to do that. I suggest that the law may be so open and so vague that indeed it may force a person into that position.

For example, I practice at a hospital that receives Federal funding. I could very easily see that that hospital may not allow me to be on the staff if I chose not to do that procedure.

Senator METZENBAUM. I think there is some validity to my point, and let me take another look at it.

Senator Simon.

Senator SIMON. I have just one question to Dr. Glasow. You mentioned—and I don't know the statistics—but that half the women who have abortions have not practiced birth control, and you are interested in preventing abortions. I think we all share that. Does your association then encourage the practice of birth control, and are you doing anything in a constructive way to encourage sex education and that sort of thing?

Dr. GLASOW. Senator, we do not take a position on contraception. What I am articulating is the fact that approximately half of the women were not using contraception in the month in which they became pregnant—it is certainly a higher number who are not using contraception on the occasion they became pregnant—indicates that women are using abortion as a method of birth control in the United States. We believe that the public does not support that, and we think the public would support legislation to restrict abortion for that purpose.

Senator SIMON. Let me ask you this. Do you find any inconsistency in being opposed to abortion and yet not promoting what would prevent abortion?

Dr. GLASOW. No.

Senator SIMON. I have no further questions.

Dr. GLASOW. I believe I can understand—judging from the tone of your question, you see an inconsistency. I think we have a difference of opinion.

Senator SIMON. I think we do differ on that.

Thank you, Mr. Chairman.

Senator METZENBAUM. Senator Adams.

Senator ADAMS. Dr. Glasow, does your organization take a position on Title X, the Family Planning Services bill?

Dr. GLASOW. We take a position urging adoption of appropriate legislation to separate or to complete get abortion out of the Title X program.

Senator ADAMS. But you would support Title X contraceptive and counseling programs for prevention of pregnancy?

Dr. GLASOW. We would take no position. If abortion were removed using the type of amendments that we would propose and have urged in previous hearings on the Title X bill, we would be neutral on it, but we would want to make sure that Title X is not promoting abortion or abortion counseling and that kind of thing.

Senator ADAMS. Well, it isn't very helpful to us if we've got a split as we have in many cities, where that is being observed, and the abortion portion of a planning system is divided between the clinics that can perform abortions and those that are for family planning and for contraception and so on; and if you don't take any position, then aren't you kind of opposed to the whole thing?

Dr. GLASOW. Title X, as currently administered, includes abortion counseling and referral. We back the regulations that were initially proposed in the Reagan Administration and are currently in the process of going through the courts, and we urge that Congress do nothing to change that procedure right now. We want that to go forward. We believe those regulations should go into effect that would get abortion out of the Title X program. And if they do go into effect and that happens, we would support that initiative.

Senator ADAMS. Dr. Gross, do you have any comment on that?

Dr. GROSS. No, I don't.

Dr. FORREST. I do.

Senator ADAMS. Dr. Forrest.

Dr. FORREST. I think that the prevention of the need for abortion is the key road we need to take. We have made estimates of the effect family planning services supported by Federal funding, including Title X, including Medicaid and the block grant, the effect that has on avoiding abortion in the United States today, and our estimates are that there are about 4.5 women in the United States using reversible contraceptive methods, depending on these publicly-funded sources. About half a million abortions per year are prevented among those women because they were able to obtain contraceptive methods at these family planning providers.

If we didn't have that system in place now, we would have another third higher level of abortions. Contraception is the way to prevent pregnancy among people who are having sex and don't

want to become a parent. That is the route we need to take. Your committee has done admirably in reporting this bill, and it is very important that we as a country and certainly Congress move forward and do not delay its action.

Women need that. You cannot blame them on one side because they became pregnant and not give them the means the help to avoid the pregnancy.

Senator ADAMS. Dr. Glasow, what does your organization think about educational programs intended to prevent teen pregnancy?

Dr. GLASOW. Again it would be analogous to our position on contraception. If they start to talk about abortion, promote abortion, we are against that activity, and we in fact have a curriculum that we urge that high schools utilize on the abortion issue because we think most of the curriculums adopt a pro-abortion stance. But other than the abortion issue, we do not get involved in the sex education area.

Senator ADAMS. Thank you, Mr. Chairman. I have no further questions.

Senator METZENBAUM. Thank you very much, and I thank this panel very much.

Senator SIMON. Mr. Chairman, may I just add one more comment?

Senator METZENBAUM. Please.

Senator SIMON. It does seem to me there are areas where we ought to be exploring what can be done in a positive way. Now, I understand what you are saying, Dr. Glasow, and your position. But we are doing too much shouting at each other and not listening to each other.

For example, we have about one million teenage pregnancies each year, 400,000 of which end up in abortion. We know that people who drop out of school are much more likely to have abortions. If we could constructively work on the whole question of young people, particularly girls, who are having trouble in school and see that they don't drop out of school—now, it is not dramatic; you don't get any emotional fervor, demonstrations and everything—but clearly, we would be doing something very constructive to prevent abortions and to prevent all kinds of other things in our society.

I think we ought to be exploring these positive options more to find areas—we cannot agree, perhaps, on whether you promote contraception or not—but let's find areas where we can agree and do some constructive things. Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Senator Simon.

I do want to make an announcement that Senator Hatch has a deep interest in this subject, but he is managing the crime bill on the floor, and he will submit questions subsequent to the hearing and submit a statement.

[The prepared statement of Senator Hatch follows:]

PREPARED STATEMENT OF SENATOR HATCH

The abortion debate is fueled by strong arguments and sincere feelings on both sides. This issue has become very emotional in the last couple of years. We have seen the passion and power of both

sides following the recent Supreme Court decision in *Webster* and the ensuing battles in state legislatures throughout the country.

The seriousness of this issue cannot be ignored when we see that there are close to 2 million reported abortions in this country each year. In my own State of Utah, there were 4,149 reported abortions in 1988. We can only guess at the number of abortions that are not reported.

Today, we will be hearing from a number of experts who will discuss the issues surrounding such terms as "viability" and the circumstances under which an abortion would be medically necessary. We will also be hearing from other experts about the reasons why women have abortions. Examining the ramifications of these issues is important as we look at S. 1912, the "Freedom of Choice" bill.

Mr. Chairman, I have a number of concerns over this "so-called" Freedom of Choice Act. The bill sponsors claim that this legislation codifies *Roe v. Wade*; but, the bill actually goes much further. It eliminates all state restrictions on abortions, thus allowing abortion on demand. The bill is even broad enough to allow an abortion any time during the nine months of pregnancy.

A significant number of the American people would be uncomfortable with this legislation which allows abortion as a method of family planning. Today, many women are not given choices about abortion; rather, they are counseled that abortion is their only option.

I hope that we can work to find the support necessary to show women that there are better choices than abortion. Mary Cunningham Agee has captured this idea with the Nurturing Network. This is a unique support network which enables women who have made the choice to take on the responsibility of an unexpected, even unwanted, pregnancy to not only cope with the obligations of parenthood but also to appreciate its joys.

I have written testimony by Mrs. Agee describing this program in more detail. I would ask unanimous consent that it be included in the record. In it, she describes the comprehensive and compassionate services that are offered to women in all 50 States. The work of thousands of volunteers in this network has meant that hundreds of healthy and happy babies' lives have been saved and real choices have been provided to women who were told that an abortion may be their only option.

Mr. Chairman, I support this program and others like it which reach out to women who feel they have no other choice except to have an abortion. I hope that we in Congress can also find the means to offer support to these women and, at the same time, take the necessary steps that preserve human life. That is our true challenge.

I am particularly pleased that Dr. John Nelson, President of the Utah Medical Association, is here today. Dr. Nelson has worked many years as an obstetrician and gynecologist in Utah. He has expertise in reproductive health and will provide this committee with valuable medical information on terms contained in the bill. I thank the other witnesses for appearing today, and I look forward to hearing all their views.

Senator METZENBAUM. Did you wish to add something, Dr. Gross?

Dr. GROSS. Yes, I'd like to make a comment on the question of advances in technology since *Roe v. Wade*, which I think Dr. Nelson raised.

I think we have to be careful in thinking about these technologies as to what is relevant to this bill and what is not. Dr. Nelson raised the issue of fetal diagnosis and fetal surgery, which are very exciting areas. These in general relate to improvements in the management of babies who are beyond the period of fetal viability which this bill is talking about. These fetal surgeries can on occasion be done before 23 weeks, but usually they relate to procedures that are done after 23 or 24 weeks, so I would see them as not impacting on this bill but relating more to improving medical care for babies who are born with malformations.

In terms of viability as defined by this bill, what we are talking about is the survival of very premature infants, and I think there is agreement now that at the moment, at least, our technology seems to have plateaued and we need a major breakthrough, a major change in technology to make further inroads in that direction.

Senator METZENBAUM. Dr. Nelson, do you wish to add something?

Dr. NELSON. Yes, sir. In response to that, my comments regarding technology had to do with simply the fact that viability is quite differently defined now than in 1973.

But the other point I wish to make, sir, is that I served on a task force on teen pregnancy and its problems in the State of Utah. We did a very intensive survey and found a couple of very interesting things with regard to teens, which relates to teens only.

No. 1, the number of teens in Utah who are sexually active or admitted to being so—and we think the sample is valid—is about half what it was in the rest of the country. But of more concern to me is the fact that of those young people who are sexually active, 49.8 percent did not wish to continue to be; 49.8 percent of teens in Utah who are sexually active do not wish to continue to be.

It would seem to me therefore that one of the very positive things that could be done is to teach those young people the value of sexual abstinence--not contraception, not the need for abortion—but living the community standard.

Senator METZENBAUM. Dr. Nelson, I think that is a very thoughtful comment, but I have to confess to you that I think it is quite unrealistic.

Dr. NELSON. Not in Utah, sir. [Laughter.]

Senator METZENBAUM. You may say not in Utah, but you also tell me at the same time that 49.8 percent of the young people are engaging in——

Dr. NELSON. No, sir; about 30 percent are engaging in activity, and of those, 49.8 percent don't wish to continue.

Senator METZENBAUM. All right. Thank you very much. I don't know if Utah is unique, but I——

Dr. NELSON. It is. You are welcome to come.

Senator METZENBAUM. Thank you very much.

Our next panel consists of Ms. Jeannine Michael, Clinic Director of The Hub, South Bronx, NY; Dr. William Peterson, Chairman of the Department of OB/GYN at Washington Hospital Center in

Washington, DC; Ms. Delores Bernadette Grier, President, Catholics United Against Abortion of New York; Dr. Vincent Rue, Co-Director of the Institute for Abortion Recovery and Research of Portsmouth, NH.

Ms. Michael, we will be happy to hear from you first.

STATEMENTS OF JEANNINE MICHAEL, CLINIC DIRECTOR, THE HUB CENTER FOR CHANGE FOR SOUTH BRONX TEENS, SOUTH BRONX, NY; DR. WILLIAM F. PETERSON, CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, WASHINGTON HOSPITAL CENTER, WASHINGTON, DC; DELORES BERNADETTE GRIER, PRESIDENT, CATHOLICS UNITED AGAINST ABORTION, NEW YORK, NY; DR. VINCENT RUE, CO-DIRECTOR, INSTITUTE FOR ABORTION RECOVERY AND RESEARCH, PORTSMOUTH, NH

Ms. MICHAEL. Thank you, Mr. Chairman.

My name is Jeannine Michael, and I am a clinical social worker, certified by the State of New York and currently employed as clinic director of Planned Parenthood's New York City Center, The Hub, which is located in the South Bronx.

Since 1973 I have specialized in counseling women making decisions about pregnancies they did not plan. I have worked in hospital settings and freestanding abortion clinics, in both first and second trimester abortion programs, with all modalities—vacuum aspiration, saline installation, and the D&E procedure. I also have a private practice in which I counsel women, partners and their families around problem pregnancies. That includes making the decision and following them following an abortion in both short-term and long-term treatment.

I have trained and supervised hundreds of counselors and conduct training workshops and seminars at a national level for counselors in the field throughout this country.

I have written a book entitled "Mom, I'm Pregnant," which is a guide for teenagers and their parents, which outlines the range of decisions that can be made when they are pregnant and the physical and potential emotional aspects of each choice.

The goals of counseling include the responsibility of the counselor to resolve and set aside her own personal feelings about sexuality, premarital sex, pregnancy, birth, abortion, and to maintain a neutral posture regarding the outcome of the pregnancy and the use of a nondirective approach in counseling.

Counseling is an opportunity for a woman to tell her story. It enables her to examine her alternatives, to identify any conflicts that she may have around that pregnancy, and to explore the advantages and disadvantages of each alternative within the context of her own life situation. It is the counselor's responsibility to provide necessary facts about each alternative. That includes risks, benefits, complications, costs, resources for help and, if the patient is considering having an abortion, to provide accurate and detailed information about the procedure, the risks and complications, the recovery period and aftercare. But most important for the woman seeking that choice, whatever it may be, is to look at each choice within the context of what she feels she can best cope with, and by exploring ways to manage going to term, how to get practical and

emotional resources needed, if she can work, if she can finish school, what kind of help can she expect from her partner, her family, and if no help can be gotten, how she can manage to do that alone if she intends to go to term; if she chooses abortion, how she can cope with that decision within the context of her life situation and her own value system.

In all my years, 17, of practicing and counseling women around this issue, I have never met a woman who made a casual choice to have an abortion. Sometimes a pregnancy is experienced as a physical or psychological threat, and that would be clear and true in the case of a 33 year-old woman who was married and recently separated from her children and who had two school-age children. She wanted to be married, she wanted to have another child, but her husband had left her. She worked as a teacher to support her own two children. Her religion taught her both that divorce and abortion were wrong, so she was in great conflict.

We looked together at how she would manage to have that third child. She had no supports economically or socially. She had no family support. She would have to stop working. She felt that if she stopped working to care for her baby, she would have to live at a poverty level. If she continued to work, she didn't have enough money to pay for child care. So her inability to manage alone put her at risk of losing custody of her own children if she went to term and had that baby.

We looked at how she could manage her feelings if she had an abortion. And despite the disapproval of her own church, her own feelings of loss and sadness at having to terminate that pregnancy and the disappointment in the failure of her marriage, she felt she could best cope with abortion because she saw it as a choice between the children she already had, who depended upon her to provide an income, and the potential child that would require her to relinquish that income.

So she chose abortion because she thought it was a choice for survival.

In some cases it is a crisis of choice between competing values. That would be true of a 16 year-old who wanted to get married to her 18 year-old boyfriend and have her baby, but she presented with a conflict because she had a mentally ill mother and an alcoholic father who beat the mother.

The mother accompanied her to the clinic when she came for counseling, and it was clear that this child served a parental role in that family. The mother was childlike, dependent and withdrawn.

She felt that she could not tell her father she was pregnant because if she left the home to get married, the mother would be punished for her pregnancy.

She decided that she was caught in a dilemma of trying to balance her own needs against her mother's, and she felt that she needed to provide the only barrier of protection available to her mother by putting herself between her and her father.

She saw her choice for abortion as a moral choice between her obligation to her mother and her own desire to be married and have a baby.

However, I followed her for 2 years, and when she turned 18, she got married, she left the home, she had a sanctioned marriage, and following that became pregnant and had a baby. However, she had the blessing of both parents at that time and a traditional marriage and family.

I present these cases to you as examples of the kind of women's stories that counselors hear every day. In the abortion debate, the individual woman is unheard and unseen and nonexistent. I assure you, they exist. These are their stories. The risks of pregnancy are the woman's alone; so should the decision to terminate her pregnancy be her own.

Thank you.

Senator METZENBAUM. Thank you for a very lucid statement.

[The prepared statement of Ms. Michael follows:]

PREPARED STATEMENT OF JEANNINE MICHAEL

My name is Jeannine Michael and I am a clinical social worker, certified by the State of New York and currently employed as clinic director of Planned Parenthood of New York City's "The Hub: A Center for Change for South Bronx Teens." This center is located in the Congressional District with the lowest per-capita income in the Nation and one of the highest teen pregnancy rates. It offers youngsters growing up in poverty a broad range of services to help them break the generation-to-generation poverty cycle and enter the economic mainstream. We provide personal counseling, academic tutoring, pre-job training, plus basic health care—including family planning services, abortion services, and prenatal and well-baby services.

For the past 17 years, I have specialized in counseling women who need to make decisions about pregnancies they did not plan. I have also written a book entitled "Mom, I'm Pregnant," a guide for teenagers and their parents that outlines the issues they have to address and the range of decisions they can make when they are faced with an unplanned pregnancy.

Decision-making counseling does not seek any predetermined outcome. The woman's decision about whether to continue or end her pregnancy must be her own, free of coercion. It is, therefore, the responsibility of the counselor to resolve and put aside her own personal feelings about premarital sex, pregnancy, abortion, and birth—so she can be objective and ensure that she does not do or say anything to influence the woman's decision about the outcome of her pregnancy.

The goal of counseling is to enable the woman to examine alternatives, think them through, and arrive at what she feels is the best possible decision for her, in her particular life circumstances. The first task is to help her identify any conflicts she may have about being pregnant. The counselor invites the woman to talk about her partner, her parents, and other significant people in her life. The counselor asks how the pregnancy occurred and what the woman's feelings are about her situation. Discovering what the pregnancy means to her is central, along with exploring in detail how she would cope with each of the options open to her—going to term and raising the baby, alone or otherwise; going to term and giving the child up for adoption; or abortion. Through this process of exploring the potential short-term and long-term consequences of each alternative, the woman is able to clarify her feelings and reach her own best decision.

Part of helping the woman evaluate her options is making sure she has all the necessary facts about each of them—facts about risks, benefits, costs, resources for help. If the woman is considering abortion, the counselor provides accurate and detailed information about how the procedure is performed, the potential risks and complications, and after-care. She answers honestly whatever questions the woman may ask, including questions about pain and fetal development. Post-abortion counseling is available; and when necessary, referral for further counseling or social services is standard operating procedure.

All women are at risk of unplanned pregnancy from puberty to menopause, whether or not they contracept, are rich or poor, black, white, red, or yellow, and no matter what their religious beliefs.

And sometimes, the pregnancy is experienced as a physical and psychological threat to the woman's very existence. It precipitates a crisis that renders her usual coping mechanisms unequal to the circumstances in which she finds herself.

That was true of a 33-year-old mother of two school-age children, recently separated from her husband. She was getting minimal child support and had to work full-time to support herself and her children. Pregnancy meant having to choose between the children she had who depended on her to provide an income and a potential child who would require her to relinquish that income, thereby threatening the existence of all of them. She chose abortion, because it represented a choice for survival.

Sometimes the pregnancy is a crisis of choice between competing values—as with the 16-year-old whose mother was periodically hospitalized for mental illness and whose father was an alcoholic who sometimes beat the mother. She felt that she provided the only barrier of protection for her mother from her father. For her, abortion was a moral choice in which she placed her obligation to her mother above her own desire to have a baby.

Even in intact low-income working families, a teenaged daughter's pregnancy can often produce the kind of destabilizing stress that puts the entire family at risk. But if the teen is living in an already dysfunctional family that has problems of child abuse, drug abuse, substandard living conditions, or even homelessness—then an unplanned pregnancy can result in the teen's becoming a "throwaway" child. The overloaded, fragile family system disintegrates and cannot provide for the physical or emotional needs of the teen.

This is what happened to the 15-year-old who delayed telling her mother about her pregnancy out of fear of abandonment. And in fact, when the mother found out that her daughter was 18 weeks pregnancy, she left the girl sitting in my office and told her not to return home—she could no longer live with her.

Although these three women's stories reflect complex life situations, they do not represent the most desperate cases. These kinds of circumstances in women's lives are normal. What makes them seem extreme is that most people don't get to hear individual woman's stories. In the debate over abortion, individual women are unheard and invisible, non-existent. I am a counselor and I assure you they exist, and these are their stories—just a small sample of the kinds of stories counselors hear every day.

Fear of the reactions of significant others is but one of the reasons women delay seeking abortion services. Others are ignorance of the symptoms of pregnancy, inability to obtain money in time to pay for an early abortion, the need to travel far from their home communities to get abortion services, and abandonment by partners unable or unwilling to cope with the stress of fatherhood.

Every contraceptive available to women today has a failure rate—that, too, is a reality for women.

In all my 17 years' experience, I have never talked to a woman whose choice of abortion was casual. It is a choice made in the context of each women's unique circumstances and influenced by one or several of the factors I have mentioned. It is this complexity of problems and life circumstances that compels us to respect her right to choose.

The risks of pregnancy are the woman's alone. So must the decision to terminate pregnancy be the woman's alone.

Senator METZENBAUM. Dr. Peterson.

Dr. PETERSON. Mr. Chairman, thank you for the opportunity of being here.

I am Dr. William Peterson, board-certified, chairman of the Department of Obstetrics and Gynecology at the Washington Hospital Center, the largest hospital here in Washington, DC.

Having been a physician for over 44 years, with most of it devoted to women's health care, I have had the opportunity to see many changes occur. Pertinent to this hearing was the introduction of the birth control pill and later the intrauterine device, giving women greater opportunity for reproductive freedom.

Unfortunately, too many males saw this as the release of their responsibility, and society did and still does little to reinforce personal responsibility for their sexual actions for either men or women.

Abortion, while illegal, was available to those with money and connections, and to those who were desperate enough to try old-

fashioned remedies. While many are familiar with the catheter or the coat hanger, few are aware of potassium permanganate, which produced severe burns in the woman's vagina; turpentine taken by mouth, or the famous "slippery elm".

Those do-it-yourself measures, combined with the charlatans, made abortion the leading cause of maternal death here in the District of Columbia until abortion became legal.

I for one had become demoralized by the number of woman, mostly young, who had become crippled or who had died from illegal abortion. Interesting, all of their men survived.

We opened the first outpatient facility in this area and pioneered second trimester abortion by the vaginal route in this country, first reporting our results in 1973 and later publishing our results in 11,700 cases of what has become to be known as the D&E procedure in 1983. This is the largest series of cases reported in the American literature to date.

Over 50 percent of those requesting elective second trimester abortion are teenagers; 85 percent are under the age of 30; 80 percent are single.

The reasons for waiting to seek care until the second trimester involve cost, guidance, irregular periods, most importantly, denial, and too frequently, pressure from their boyfriends to keep the pregnancy, without any concrete offers of support in any tangible fashion.

All too often, the pregnancy has advanced into the second trimester by the time that realities of life force them to face their problem.

While it has been reported that a larger number of single women are electing to keep their pregnancies, those who do come for termination are very rarely ambivalent about their decision. In my experience, those seeking termination of their genetically or congenitally abnormal pregnancies have all requested and received intensive counseling from geneticists and their physicians before electing to terminate. Were there very to be a circumstance that this had not been accomplished, it would be the physician's duty to see that it was before proceeding.

While viability is an important issue, it remains a medical decision and cannot be clearly defined until it is related to the experience in all nurseries or at least those on a regional level, considers the quality of life for the survivors, and has put in place provisions for Government support for those who are disadvantaged following early birth.

Physicians who truly care for the welfare of our women, especially the young, unsophisticated and often poor, are deeply concerned over the actions of some who would take away the right to make educated choices from our women regarding their reproductive function. After all is said and done, we are the ones responsible for their care.

The specter of abortion has faced us for centuries, and sadly, it is likely to continue to do so, whether illegal or not. Let us then marshal all of our efforts, combine divergent philosophies toward reducing the need to consider abortion as an option, through education, teaching personal responsibility for our actions, especially the

male, and encouraging research for better methods of conception control.

In the meantime, let us assure that abortion is provided in a safe, supportive manner, with appropriate public health inspection and surveillance of those providing this service for those making an educated decision to carry out this procedure.

Thank you, sir.

Senator METZENBAUM. Thank you very much, Dr. Peterson.

[The prepared statement of Dr. Peterson follows:]

WASHINGTON
HOSPITAL
CENTER

DEPARTMENT OF OBSTETRICS
AND GYNECOLOGY

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PREPARED STATEMENT OF WILLIAM F. PETERSON

Having been a physician for over 44 years, with most of the time devoted to womens health care I have had an opportunity to see many changes occur. Pertinent to this hearing was the introduction of the birth control pill and later the intrauterine device giving women a greater opportunity for reproductive freedom. Unfortunately, males saw this as a release of their responsibility and society did, and still does, little to reinforce personal responsibility for either men or women - Abortion, while illegal was available to those with money and connections and to those who were desperate enough to try old fashioned remedies. While many are familiar with the coat hanger or catheter, few are aware of the potassium permangeate tablets which produced severe burns in the vagina or the famous slippery elm. These do it yourself measures combined with the charletons made abortion the leading cause of maternal death here in the District of Columbia until abortion was legalized.

Coming from the years abortion was illegal we were careful, when we set up the first out-patient abortion facility in the District, to set the highest possible standards of care. Trained counsellors relate one on one with the patient throughout the whole process, including holding their hands during the procedure, and follow-up afterwards. Only trained obstetricians/gynecologists work in the clinic and on-going quality control measures are reviewed periodically. Costs were kept low, well below those in the private sectors, to allow access to all economic classes.

It soon became apparent that care would have to be available to those beyond the first trimester of pregnancy as hysterotomy (like a cesarean section) or saline were not the appropriate answer because of complications and cost.

110 IRVING STREET, N.W.
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We were the first in the United States to develop what later became to be known as the D & E procedure and our results were reported at a National meeting in Las Vegas in 1973 showing it to be safer, quicker and less costly than other techniques utilized for second trimester abortion. In addition, it provided more emotional support for the patient during this trying time.

As time went by we gained more experience, developed new instrumentation and were able to help patients who found themselves further along in the second trimester. Our results in over 11,700 patients was reported in Obstetrics and Gynecology in 1983 - the largest series reported to date describing inovative techniques to decrease the incidence of complications. Currently electively we terminate pregnancies up to 19 menstrual weeks of pregnancy.

This experience has enabled us to meet the needs of those faced with genetic or congenital abnormalities of the fetus, those with serious medical complications that endanger the mother's life and those whose fetus has died while in the uterus. For many years these patients were often 20-25 weeks pregnant at the time these conditions were diagnosed or it was apparent that the mothers life would be endangered by continuing the pregnancy. Increased diagnostic sophistication is currently bringing many of these patients in somewhat earlier in their pregnancy.

We have learned many things throughout our years of experience all important for optimum health care - Notable are:

1. Initially we made abortion a two day process. Screening and counseling the first and the procedure on the second day. A study, however, conducted on over 1500 patients and in several other clinics proved that making abortion a 2 day procedure was NOT in the patients' best interest because it resulted in unnecessary delay, increased psychological stress and made her a poor candidate for a surgical procedure. There were no patients who changed their mind during the delay who had not already been labeled as ambivalent.

2. Decisional counselling is not actually required by many patients but this must be reviewed by the counsellor in all patients. Those demonstrating any ambivalance must receive further counselling or other professional support before the procedure should be contemplated.

3. One on one counselling and support during the procedures represents optimal patient care and exceeds that given in any other surgical procedure performed today.

4. Contraceptive counselling, detailing all the available methods is mandatory. Along with this, and vital for appropriate education, is guidance in personal responsibility for one's health and moral code. It is OK to say NO!

5. Follow-up must be obtained by the counsellor, to insure privacy, in all cases - both psychological and medical - and wherein possible follow-up examination must be provided at no cost by a physician.

6. Pre-operative history and physical examination must be obtained on all patients. Medical complications must be thoroughly evaluated before progressing further and appropriate precautions taken wherein indicated eg - prophylaxis for cardiac disease. Those with more serious complications might best be referred to a hospital based facility.

7. Accurate appraisal of the pelvis is mandatory with liberal use of sonography to accurately date the duration of pregnancy, especially in those patients who are obese or approaching the limits of the physicians capability by dates or pelvic examination. Those with fibroids or other pelvic masses mandate sonographic evaluation. All sonography should be performed by trained personnel with appropriate equipment and read by a physician trained in this field.

8. Appropriate laboratory evaluation must be performed on all patients including, at a minimum, hemoglobin/hematocrit, Rh factor and blood type with a pilot tube.

9. All physicians responsible for patient care should be carefully screened and their professional qualifications thoroughly researched. No physician should perform second trimester procedures without first documenting proficiency in first trimester procedures. Advancements into terminating larger pregnancies by D & E should be on a step by step basis with proper supervision before being given unsupervised privileges.

10. All patients must be fully informed of the risks and complications of the abortion process, including alternatives, and all her questions answered to her fullest satisfaction. This must be documented by the patient's signature, witnessed and kept on file with the patient's chart.

11. The facility must posess adequate supportive means and measures to meet the needs imposed by known complications of the procedures. These must include but are not limited to oxygen, suction, I.V. fluids, and appropriate medication.

12. All Free Standing Facilities - Back-up arrangements must be established in writing with a nearby hospital to assure easy access and speedy support in the event of emergencies. Transportation should preferably be by ambulance, or if by private automobile the patient must be accompanied by a nurse or physician.

13. All tissues must be submitted to pathological examination unless fetal parts can be clearly identified. All tissues should be disposed of through a recognized pathology laboratory or other means according to local Public Health Regulations.

14. Appropriate, specific, and preferably written instructions and follow-up must be given to all patients who fail to demonstrate adequate tissue for their expected duration of pregnancy or turn out to have a molar pregnancy. This must be clearly documented.

15. The operative procedure must be clearly documented so as to allow others reviewing the case to clearly understand what medications were given, the operative procedure that was performed, and the patient's condition on leaving the operative area.

16. Appropriate recovery areas must be established and the patient observed by trained personnel for an adequate length of time to insure the patients condition is stable on discharge. This will generally be a period of one hour although those late in the second trimester should generally be observed for two hours. Careful documentation of the patients status must be made during this time and a physician readily available for patient evaluation.

17. Upon discharge the patient should be given all medications necessary for her post-operative health. These may include antibiotics, an oxytocic such as ergotrate and birth control measures such as the pill. The cost, if any, of these medications should be included in their over-all charges. This must also include Rho-gam when indicated.

18. The patient must be given typewritten instructions for her on-going care including telephone numbers where she may have concerns answered or receive guidance and care in the event of complications. This should be a 24 hour service monitored by a professional.

19. All free standing facilities should be licensed, supervised and inspected by appropriate local Public Health agencies to insure proper, safe standards of care. These standards should match those established for free standing Surgi-Centers.

19. Second trimester abortion by D & E in free standing facilities should probably be limited to those who have not exceeded preferably 16 weeks and certainly 18 weeks by menstrual dates. Patients exceeding these limits should be managed in hospital based facilities.

20. Those hospitals refusing to support this service, for other than religious grounds, should be encouraged to comply if at all possible in order to properly serve their community.

The issue of viability has received considerable attention although the term only addresses life and not the quality of that life - a vital component warranting serious concern. In my professional life I have seen the period of viability drop from 30 weeks to 28 weeks where it remained for a long period of time. In the recent years, with increased knowledge and sophistication of care, this has dropped to 26 weeks and reaching, in some areas, towards 24 weeks. There are antedoctal stories of fetusus surviving having been born even younger than 24 weeks, however, they remain as isolated incidents. In attempting to define viability, which should be a medical decision, many factors must be evaluated. One cannot make a decision based on data from a few highly specialized facilities in the country and then apply this guideline to the nation as a whole, if the larger number of nurseries cannot provide this level of support to the newbofn. Nor should this determination be made without careful evaluation of the quality of life that will be available to that surviving infant - at least until there are government sponsored facilities to properly care for those who are disadvantaged on an on-going basis - even for a

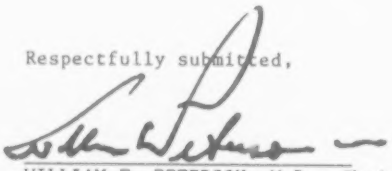
This is truly a most difficult question and one that requires input from many sources before a decision can be reached.

It would clearly be inadvisable for any government agency to make this determination without thorough input from a span of medical resources. To do so without such input would impact on the general practice of obstetrics and could create a medico-legal dilemma.

Physicians who truly care for the welfare of our women, especially the young, unsophisticated and often poor are deeply concerned over the actions of some who would take away the right to make educated choices from women regarding their reproductive function. AFter all is said and done we are the ones responsible for their care.

Let us direct our efforts toward reducing the need to consider abortion as an option through education, teaching personal responsibility for our actions, especially the male and encourage research for better methods of conception control. In the meantime let us assure that abortion is provided in a safe, supportive manner with appropriate Public Health inspection and surveillance of those providing this service.

Respectfully submitted,



WILLIAM F. PETERSON, M.D., Chairman
Department of Obstetrics & Gynecology
Washington Hospital Center

Senator METZENBAUM. Ms. Grier.

Ms. GRIER. Good morning, and thank you very much. I am very happy to be here, Mr. Chairman. I am somewhat nervous; this is the first time I have ever done this.

I would like to say first in regard to the focus on health issues that regarding abortion, I believe that one of the reasons so many women, especially poor women, minority women, black women in particular and young women, have abortions is because they really do not know what an abortion does, how it is performed and the effects after they have an abortion and the complications.

I would like to say first that being pregnant is not a pathological State. It is a physiological condition, which really does not require medication or treatment by a doctor unless there is some difficulty.

The pregnant woman really should not be so much seeking an abortion, but adequate health care, that would protect her and the unborn child from physical harm. And we hear the advertisements about that on the TV and radio, such as alcohol, tobacco, drugs and other infectious diseases like German measles.

Also, a woman should be providing nourishment to maintain good health for the mother and the unborn child. This prenatal health care is essential especially among black women, where the infant death rate is 18.2 per 1,000 births as compared to only 9.3 per 1,000 white infant births.

Abortion is the termination of a pregnancy which results in the death of a developing human. This is how it is defined in *Webster*'s medical dictionary 1986. Abortion, as many people may believe, is not a medical procedure; it is invasive surgery where the surgeon uses steel instruments to terminate the life of the unborn child in the mother's womb.

The word "terminate" means "to end" and is also used popularly to indicate killing—for example, in Arnold Schwarzennager's film, "The Terminator", "terminator" means "to kill". And in the abortion area, the terminator is the doctor, and the target of the terminator is the defenseless child in the womb.

Abortion is an unnecessary surgery and is usually performed by a doctor who has been trained to heal and cure when pathology indicates it, but now he has stooped to killing. The doctor surgically invades the body of a woman he has not seen before nor will ever see again.

This is the only surgery where a patient is not first examined and that there are not postsurgery visits, while it is extremely important that a minor have an adult with her when they have an abortion.

Post-abortion physical complications such as the incomplete abortion, where parts of the body of the unborn child remain in the womb, and excessive hemorrhaging have been very detrimental especially to many of our young people, and some of our older women, following the psychological trauma after the abortion—which does not always occur immediately after, but sometimes is delayed for a year or more—they regret what they have done, they have guilt and anxiety, which will lead them to depression, use of drugs, and attempted suicide.

I learned from a friend of mine recently who works with drugs that many of the youngsters that she sees who are involved with

drugs have had abortions and have sort of looked to drugs as a way of escape.

Advances in science have opened the womb that was once hidden, so we can now observe the growth and the movement of the unborn child through ultrasound. Surgeons are performing corrective surgery, administering blood transfusions, medication and electrocardiograms on the alive and growing child in the womb.

Yet the child terminators endeavor to hide the humanity of the unborn by describing the child as a "fetus". Now, this is a Latin word, it is the word that is usually used in the medical and scientific field, but it has been introduced to the public to dehumanize the humanness of the unborn child and his or her right to birth.

The medical dictionaries define "fetus" as "a child in the uterus", "a developing individual", "an unborn child". Fetal experimentation or fetal extermination is not as offensive to the public as child experimentation and child extermination.

Sad to say—and I would like now to say that I am speaking as a black woman; I was speaking before as a woman who was brought into the pro-life movement in 1977 by the Reverend Jesse Jackson, who has now turned around, but who was very influential in my being on this side of the fence and being very involved that life begins at conception—now, sad to say that Reverend Jackson and many of the black men and women in Congress will be recorded in history as having contributed to the demise of the African American race in this country. They are rejecting their own African heritage, which regards the unborn as those waiting to be born.

As they say in the African villages, no one knows whose womb will bear the chief.

I would also like to say that 97 percent of the abortionists who kill unborn black babies in the inner city are white American males, and they are paid, directly or indirectly, by funding from the United States Government.

Abortion, I believe—and I believe that most black people truly believe—is morally wrong and contrary to our culture.

I thank you very much, Mr. Chairman.

Senator METZENBAUM. Thank you very much, and I think your first appearance before a Senate committee was just great, and we very much appreciate your being with us.

[The prepared statement of Ms. Grier follows:]

CATHOLICS UNITED AGAINST ABORTION

Good morning. Thank you for the opportunity to speak at this hearing on health issues involved with women who desire to terminate their pregnancies before the natural term of forty weeks.

Being pregnant is not a pathological state, it is a physiological condition which does not require medication or treatment by a doctor unless there are abnormalities. The pregnant woman should receive adequate health care that will (1) protect her and the unborn child from physical harm - such as alcohol, tobacco, drugs or infectious disease (German measles, AIDS) and (2) provide nourishment to maintain good health for the mother and the unborn child. This prenatal health care is essential, particularly among the Black women where the infant death rate is 18.2 per 1000 births as compared to 9.3 per 1000 white infant births.

Abortion is the termination of a pregnancy which results in the death of a developing human, according to Webster's Medical Dictionary - 1986. Abortion is not a medical procedure, it is invasive surgery where the surgeon uses steel instruments to terminate the life of the unborn child in the mother's womb. The word terminate means to end and is also used to indicate "killing". For example, Arnold Schwarzennager's film, "The Terminator". The terminator in the abortion arena is the doctor and the target of the terminator (TOT) is the defenseless child in the womb.

Abortion is unnecessary surgery usually performed by a doctor who although trained to heal and cure when pathology indicates it, now stoops to killing. The doctor surgically invades the body of a woman he has not seen before, nor will see again. This is the only surgery where a patient has not first been examined and there are no post surgery visits. Post abortion physical complications such as incomplete abortions where parts of the body of the unborn child are left in the womb, excessive hemorrhaging, infection, hormonal body changes, all must be treated by another doctor without the benefit of medical records. Psychological trauma following abortions due to guilt, regret and anxiety have led women to depression, use of drugs and attempted suicide.

Advances in science have opened the womb, once hidden, and now we may observe through the technology of ultra-sound movements and the growth of the unborn child. Surgeons are performing corrective surgery, administering blood transfusions, medication and electrocardiograms on the alive and growing child in the womb.

The child terminators endeavor to hide the humanity of the unborn by describing the child as a "fetus". This latin word is a medical term which is defined in Webster's Medical Dictionary - 1986 as "a developing human." In other medical dictionaries the definitions are "a child in the uterus", "a developing individual", "an unborn child."

This scientific terminology was introduced to the general public to deny the humanness of the unborn child and his/her right to birth. Fetal experimentation or fetal extermination is not as offensive as child experimentation and child extermination.

After many years of the civil rights struggle for equal opportunity in housing, education and employment, Black Women have only been granted the right to kill their children in the womb. Free health care only includes abortion - the termination of a pregnancy which results in the death of the human embryo or fetus - the child.

Black women never requested, demanded nor demonstrated for the right to have an abortion. It was thrust upon us as a solution to our social and economic crises. The White master is still telling Black people what is best for us - death instead of life.

We are a God-loving, God-fearing spiritual people who have been coerced into the sin of abortion. Some of these women have, in post-abortion syndrome, considered suicide, struggled to overcome the guilt of stopping the heartbeat of their baby in the womb, and others are trying to escape through drugs and alcohol.

Ninety-seven percent of the abortionists who kill unborn Black babies are White American males. Many of those "doctors" receive direct and indirect funding from the United States government. Abortion is morally wrong and contrary to our African culture.

Miss Dolores Bernadette Grier
President
Catholics United Against Abortion

Senator METZENBAUM. Dr. Rue, there is a roll call vote on, but I think we'll have time to hear from you before I leave for the floor.

Dr. RUE. Thank you, Mr. Chairman.

I am delighted to be here today. My name is Vincent Rue, and I am the co-director of the Institute for Abortion Recovery and Research in Portsmouth, NH.

This is a newly-formed, nonprofit treatment, educational and research center, exclusively devoted to the resolution of abortion trauma.

For 15 years, I have been a practicing psychotherapist in Los Angeles and have worked with hundreds of women and men who have had negative experiences after an abortion.

I have also been a consultant to the Office of Adolescent Pregnancy Prevention as well as the Office of the Surgeon General during the Reagan Administration, for his report to the President on the psychological aftermath of abortion.

From my perspective, I cannot support the Freedom of Choice Act. It seems to me this is a simple solution to a very complex psychological problem. It seems to me this bill guts our legislative and judicial experience with restricting abortions and protecting American women. It is a bill, quite simply, going in the wrong direction.

As evidence, please consider the following three important variables that are increasingly recognized as valid, but are nowhere to be found in this bill—first, informed consent; second, differential treatment for adult women versus teens and the issue of parental involvement, and third, the psychological health risks of abortion.

Let's look at informed consent first.

The doctrine of informed consent for any medical procedure is both historically sound and well-established. The more informed one is, the more responsible the decisionmaking. Clearly, women, both adults and minors, are entitled to know what an abortion does to a pregnancy. The nature of pregnancy termination and its effect on the human fetus should be clearly identified, that is, an intentional death experience.

Further, the gestational age and fetal developmental characteristics should be provided and fully explained to the patient by the abortionist counselor.

Physical and psychological health risks should also be explained and evaluated. Sadly in our country, this is not the case.

At a minimum, Senate Bill 1912 should make allowance for the dissemination of such information if women electing abortion are to truly make a knowledgeable and voluntary health decision.

Second, adolescents and parental consent. Senate Bill 1912 erroneously makes no distinctions between adult women and minors, emancipated or not. Considering the fact that approximately one-third of all abortions are obtained by women under the age of 19, informed consent becomes all the more important.

Young women may rely on less analytical approaches to the problem—that is, the problem of pregnancy and the decision about what to do with this—such as following the normative behavior of their peers, or basing decisions on romantic and unrealistic scripts.

Courts and legislators in this country have long recognized at least three compelling interests for parental participation in problem pregnancy decisionmaking:

First, the peculiar vulnerability of minor children; second, the minor's inability to make critical decisions in an informed and mature manner; and third, the importance of the parental role in child rearing.

We know from considerable research that adolescents need special attention and protection. We know that they consider fewer and different factors in pregnancy decisions and in potential child rearing, consider fewer solutions and goals than adults, delay their decisions more so than adults, differ from adults in their ability to understand moral reasoning especially from the viewpoints of others.

Senate Bill 1912 unwittingly may further the immature adolescent in her decisionmaking and worsen a deteriorating parent/child relationship by encouraging the bypassing of parents entirely. By not involving parents in the crisis pregnancy decisionmaking, we place an unfair burden of decisionmaking on adolescents.

Additionally I have provided in my written testimony seven benefits of parental involvement in adolescent decisionmaking.

Last, let me address the psychological health risks of abortion. Senate Bill 1912 pretends psychological damage from abortion is nonexistent. I am aware, from my clinical experience as well as considerable research, of evidence that substantiates the presence of negative emotional aftermath to abortion.

I spearheaded a research team that evaluated 239 studies on the psychological aftermath of abortion that was presented to Dr. Koop. All review articles and individual case reports were excluded from our analysis. It was the conclusion of this report that negative psychological aftermath of abortion exists, that it exists on a continuum from mild to severe, and that this can be the basis of a diagnosed posttraumatic disorder identified as postabortion syndrome.

Our conclusions are at variance with the conclusions drawn from existing research, namely, that abortion has few to no long-lasting psychological effects. We found further that the literature on abortion's aftermath is largely flawed both in design and methodology, and hence we do not recommend that the American public be misguided further by any conclusions based upon these flawed studies.

Thank you, Mr. Chairman.

Senator METZENBAUM. Thank you very much, Dr. Rue.

[The prepared statement of Dr. Rue follows:]

PREPARED STATEMENT OF VINCENT M. RUE

I am Vincent Rue, Ph.D., Co-Director with my wife, Dr. Susan Stanford-Rue, of the Institute for Abortion Recovery and Research, Portsmouth, New Hampshire. The Institute is newly founded and is a non-profit organization providing intensive treatment for women and men negatively affected by abortion. Additionally, the Institute provides clinical training and education for mental health practitioners both in this country and abroad, research on abortion outcomes, and a clearinghouse for abortion publications. In my clinical practice in Southern California, I have treated individuals with post abortion stress for 15 years. In the federal government, I have been a consultant to the Office of Adolescent Pregnancy Prevention, DHHS, as well as a consultant to the Office of the Surgeon General during the Reagan Administration on the abortion research report to the President.

In my prepared remarks, I will address only three areas of concern relevent to Senate Bill 1912: (1) the importance of informed consent; (2) the developmental vulnerability of adolescents and the value of parental consent in abortion decision making; and (3) the psychological health risks of abortion. None of which are addressed in the "Freedom of Choice Act."

I. The Importance of Informed Consent

If a woman is entitled to choose, she is entitled to know what her choices are and to be able to comprehend the health risks of her decision. The doctrine of informed consent for any

medical procedure is both historically sound and well established. The more informed one is, the more responsible the decision making, and the more a person feels independent and autonomous, believing in his or her own ability to control his or her own destiny. Abortion decision making is no less significant. SB 1912 does not allow and therefore rejects the fundamental treatment right of informed consent. Paradoxically, while the bill appears to promulgate the freedom to choose, it actually straight-jackets a woman in her reproductive decision-making.

Clearly, women (adults and minors) are entitled to know what an abortion does to a pregnancy. The "nature of pregnancy termination" and its effect on the human fetus should be clearly identified, i.e., an intentional death experience. Further, the gestational age and fetal developmental characteristics should be provided and fully explained to the patient by the abortionist/counselor. Physical and psychological health risks should also be explained and evaluated. At a minimum, SB 1912 should make allowance for the dissemination of such information if women electing this procedure are to make a knowledgeable and voluntary health decision.

In the absence of an opportunity to receive fetal information, the woman's attention is focused on the limited information which the abortionist/counselor chooses to disclose and her decision is thereby directed by the limited information

she receives. In such a directive counseling situation, the woman is denied the opportunity to consider thoroughly all her options, as information that would allow such has been withheld by the counselor. Indeed, without accurate knowledge, voluntary assent, and the ability to comprehend the information, a truly informed consent is not possible.

According to Kapp, "a regulation that imposes this requirement before any intrusive or risky medical procedure, such as abortion, may be performed is fully consistent with the government's legitimate interest in protecting the self determination of patients."1

Nowhere is the issue of informed consent more critical than the life or death decision concerning an abortion. In Akron v. Akron (1983) the Supreme Court affirmed "the decision to have an abortion has 'implications far broader than those associated with most other kinds of medical treatment.' Bellotti II, 443 U.S., at 649 (Plurality Opinion), and thus the State may legitimately seek to ensure that it has made 'in the light of all attendant circumstances-psychological and emotional as well as physical-that might be relevant to the well being of the patient.' Colautti v. Franklin, 439 U.S. 379 (1979)."

It should be noted that women considering abortions are in a state of heightened anxiety from their crisis pregnancy, perhaps more in need of informed consent than in other decisions. A number of factors contribute to this state and increase a

woman's vulnerability to outside pressures: (1) the shock upon realization of being pregnant; (2) the nature of the crisis pressures her to make an immediate decision; (3) the crisis pregnancy decision making and information gathering scenario unfold rapidly and often impulsively; (4) for many, the shame of the unplanned pregnancy produces a sense of isolation and a self-imposed mantle of secrecy; (5) mood swings caused by hormonal shifts tax and compound decision-making capabilities; and (6) if she is an adolescent, her decision is all too often framed in fear and based on feelings versus knowledge of options or of reproductive facts. All of these factors must be weighed carefully in counseling for crisis pregnancy decision making thereby affording a woman sufficient time for deliberation and reflection, complete and accurate information and consideration of all options, and a thorough evaluation of her individual circumstances. Only then can a truly informed and well thought out decision be made. In no way does SB 1912 address any of these concerns. While this bill restricts States, it makes no provision for the legitimate function of States to protect its female citizenry from potential harm. It is nothing short of medical and psychological decision making in a vacuum creating license - freedom without responsibility.

II. Adolescence and Parental Consent

SB 1912 erroneously makes no distinctions between adult women and minors, emancipated or not. Considering the fact that

approximately one third of all abortions are obtained by women under the age of 19 years old,2 informed consent becomes all the more important. Teenagers as a sub-population are poorly informed in many areas, and the lack of information rather than incorrect information is often the principal problem.

Reichelt and Werely examined questionnaires from 1,190 teenagers regarding contraception, abortion, and venereal disease. They found that not even a simple majority could provide the correct answer to two fifths of the questionnaire items.3 A recent study showed that more than one out of three teenage girls knew little about pregnancy and abortion and that they wanted more information. Further, the researchers concluded that one should not assume that a teenager will ask pertinent questions when she wants to know more about sexual subjects.4

Adolescents generally lack the adult benefits of life experience in autonomy and problem solving. "Young women may rely on less analytical approaches to the problem, such as following the normative behavior of their peers or basing decisions on romantic, unrealistic scripts. . . A well-thought-out pregnancy decision can enhance an adolescent's development."5

According to considerable research, adolescents: (1) consider fewer and different factors in pregnancy decisions and in potential childrearing decisions; (2) consider future solutions and goals less than adults; (3) delay their decisions more than adults; (4) differ from adults in their ability to

understand aspects of moral decisions from the viewpoint of others.6

SB 1912 may unwittingly further immature adolescent decision making and worsen a deteriorating parent-child relationship by bypassing the parents entirely.

Because the physician rarely has the time to himself counsel his patient, it is extremely important that he both encourage and require her to involve her parents. It is the rather substantial conclusion of a number of eminent scholars from the Family Impact Seminar at George Washington University in Washington, D.C. that parental involvement in teen pregnant decision making is both advisable and essential for both the pregnant minor as well as healthy family relations: "Hence, granting the adolescent the right to make her own decisions about contraceptive use or pregnancy outcome, without the counsel and support of parents, imposes an unfair burden of decision making (emphasis added) on many adolescents, especially younger ones; and it unjustly limits parental interest in the values and behaviors of their children."7

From my clinical practice, I have seen all too frequently the guilt and depression following an abortion where there has been very little prior discussion of the facts involving fetal development and the procedures of the abortion itself. These adult women can carry the burden and psychological scars of the traumatic abortion experience for years. For others, the delayed

or denied grief reaction may surface later on in life, after marriage and during a wanted pregnancy.

Courts and state legislatures have long recognized at least three compelling interests for parental participation: (1) the peculiar vulnerability of minor children; (2) the minor's inability to make critical decisions in an informed, mature manner; and (3) the importance of the parental role in child rearing.

Of note, when compared to adults, adolescents appear to have more negative emotional and psychological problems following an abortion.8

Parental consent has additional advantages as well: (1) because parents know their daughter better than most others, they can help her make better and well-informed decisions; (2) parents can help her deal with issues underlying the pregnancy; (3) parents can help her assess the medical and psychological risks of abortion and correct any erroneous beliefs; (4) parents can relay important medical and psychological information to the abortionist before the abortion and provide the emotional support for whatever the decision she might make; (5) parental involvement helps avoid the compounding problems of alienation, isolation and depression mitigating a failure syndrome or victimization and thereby help prevent the likelihood of a future crisis pregnancy and abortion; (6) if problems arise afterwards of a medical or psychological nature, the parents can be

supportive, helpful to their daughter and informative to a health care provider; and (7) family problem solving and crisis decision making is supported and enhanced and the family unit is strengthened through the maintenance of open communication and sharing.

III. Psychological Health Risks from Induced Abortion

On the basis of my experience in counseling women who have had an abortion and the research I have reviewed and conducted, I am aware of the clear evidence that substantiates the presence of negative emotional aftermath to abortion. Even the recalcitrant American Psychological Association now acknowledges: "Researchers tend to agree that, at some level, abortion is a stressful experience for all women (emphasis added)."9 SB 1912 pretends psychological damage from abortion is nonexistent.

In 1987, the American Psychiatric Association acknowledged in its newly revised manual of diagnostic criteria, the Diagnostic and Statistical Manual of Mental Disorders, III-R,10 that abortion is a "psychosocial stressor." As such, abortion may cause mild distress to severe trauma creating a continuum of symptoms. Post Abortion Syndrome (PAS) is a type of post traumatic stress disorder that is characterized by the chronic or delayed development of symptoms resulting from impacted emotional reactions to the perceived physical and emotional trauma of abortion.11

There are four basic components of PAS: (1) exposure to or participation in an abortion experience, i.e., the intentional

destruction of one's unborn child, which is perceived as sufficiently traumatic and beyond the range of usual human experience; (2) uncontrolled negative reexperiencing of the abortion death event, e.g., flashbacks, nightmares, grief and anniversary reactions; (3) unsuccessful attempts to avoid or deny abortion recollections and emotional pain which result in reduced responsiveness with others and one's environment; and (4) experiencing associated symptoms not present before the abortion, including guilt about surviving. PAS is a clustering of related and unsuccessful attempts to assimilate and gain mastery over the abortion trauma.

PAS can occur both in women who pre-abortion were relatively normal and healthy, as well as in those who were predisposed to a high stress response before their abortion.

It has been my experience in counseling hundreds of women that many experience guilt, anxiety, loss, and depression now associated with Post-Abortion Syndrome and that this condition was worsened because they received inadequate and misleading information prior to their abortion. All too often I have heard: "If I knew then what I know now, I would never have allowed myself to get into this mess."

Even more problemmatic is the sad reality that abortion is now for many women a form of birth control. Estimates now put this abortion recidivism at about 45 percent. Women with multiple abortions are generally at greater psychological risk

than women undergoing their first abortion.12

Additionally, research indicates that women who elect abortions for genetic reasons, i.e., fetal defects, are at greater psychological risk for PAS than women who elect abortion for social reasons.13 The patient should be informed of this greater risk prior to the abortion. Research also indicates that abortion choice for fetal anomalies may open the door to infanticide and dysfunctional spousal and parental interactions.14

Further, the relief of infant and family "burdens" by the physician is another increasingly common justification for neonaticide. However ameliorative by intent, any attempt to tamper with family functioning by the wholesale elimination of a family member is a perilous course. Decisions regarding the degree of fetal defect and handicap as well as subsequent quality of life are less than precise. Buchanan concluded: "There is nothing in the physician's training which qualifies him to make (such) judgments. . . to evaluate another human being's life as a whole."15

There is paradoxically greater evidence to suggest that women will have more severe and long-lasting emotional damage from an intended abortion done for mental health reasons than if the individual were to not abort and carry to term. See research summaries provided in Appendix A.

In conclusion, enactment of SB 1912 would be a vote against women. By removing all regulations restricting abortion, this Congress would be in opposition to the will of the majority of individuals it purports to serve who favor abortion restrictions. Such a decision would also be in opposition to the considerable scientific information available cautioning against wholesale acceptance of abortion. SB 1912 not only de-regulates abortion, worse, it places the States in a position of promulgating abortion. As a legislated national policy, we simply cannot afford such a naive and perilous course.

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S U M M A R Y

A REPORT ON THE PSYCHOLOGICAL AFTERMATH OF ABORTION

Presented to Surgeon General C. E. Koop

by

Vincent Rue, Ph.D., Anne Speckhard, Ph.D., James Roger, Ph.D.

and Wanda Franz, Ph.D.

I. Background

A. At the time when abortion was legalized it was viewed primarily as a women's rights issue. Few foresaw its potential to act as major psychological stressor, or how widespread its use would become, thus making the risk factors for psychological aftermath all the more significant.

B. Currently the research literature demonstrates that there are serious risks of both a medical and psychological nature associated with abortion.

1. Medical Risks of Abortion include the following: cervical injury, hemorrhage, loss of reproductive organs, subsequent infertility, ectopic pregnancy, miscarriage and fetal malformation, and death.

2. Psychological Risks of Abortion include the following: guilt, depression, grief, anxiety, shame, lowered self-esteem, distrust, hostility toward self and others, regret, insomnia, recurring dreams, nightmares, anniversary reactions, psychosomatic symptoms, suicidal ideation and behavior, alcohol and/or chemical dependencies, sexual dysfunction, insecurity, numbness, painful re-experience of the abortion, relationship disruption, communication impairment and/or restriction, isolation, fetal fantasies, self-condemnation, flashbacks, uncontrollable weeping, eating disorders, preoccupation, confused and/or distorted thinking, bitterness, and a sense of loss and emptiness.

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*Vincent Rue is Director, Sir Thomas More Clinic, Downey, CA.; Anne Speckhard is Director, Family Systems Center, Arlington, VA; James Rogers is Associate Professor of Psychology, Northwestern University, Chicago, Ill.; and Wanda Franz is Associate Professor of Psychology, West Virginia University, Morgantown, W. VA.

C. The main body of research into the psychological sequelae of abortion is still in the realm of discovery, rather than verification. Serious methodological and design flaws prevent any of these studies from being able to yield national estimates of the incidence of post abortion stress. Nevertheless, these studies are informative regarding the types, duration, and severity of symptoms of post abortion stress which do occur in those women who have been studied. Some of the most important discoveries in the health care field began with anecdotal and small sample size reports.

II. Post Abortion Trauma: A Clinical Reality

A. The support for the validity of the concept of post abortion stress is evident on the clinical level. DSM III-R identified abortion as a "psychosocial stressor." Further, it identified miscarriage as a moderate stressor, and the death of a child as a catastrophic stressor, capable of causing Post Traumatic Stress Disorder. Abortion as a perceived traumatic event may fall somewhere between moderate and catastrophic stress.

B. From a review of the literature and an analysis of the symptoms of post abortion stress, it appears that there is an identifiable continuum of psychological sequelae following abortion, that in the severe form may be labeled Post Abortion Syndrome. PAS occurs as a result of the abortion being experienced as a traumatizing event (i.e. physically invasive, emotionally overwhelming and/or perceived as a death experience). As such, it represents a specific form of Post Traumatic Stress Disorder.

C. The central components of a long-term or chronic case of PAS is the woman's reliance upon the defenses of denial and repression, and the use of avoidance behaviors to cope with her post abortion distress. Not all women who abort will necessarily develop PAS, but those that suffer the identified symptoms for more than one month following the abortion are considered to be experiencing at lease a mild form of PAS.

D. It appears likely that there are predisposing factors to PAS. However, it is imperative to note that PAS occurs both in women who pre-abortion were relatively normal and healthy, as well as in those who were predisposed to a high stress response before their abortion experience.

A healthy woman can be as hard hit by the psychological sequelae of abortion as her less healthy counterpart, based upon the impact of the abortion event alone.

E. Adolescents are at special risk for post abortion stress, due to their cognitive and emotional immaturity and the decreased acceptance among their peers for having experienced an abortion (Marecek, 1987).

F. Special diagnostic considerations include the masking phenomena that occur with PAS. Women experiencing PAS rarely connect their symptoms with an abortion event in their past, and thus, until this syndrome is better understood their secondary symptoms (i.e. substance abuse, depression, sleep disorders, suicidal ideation, etc.) are often misdiagnosed and treated without reference to the unresolved emotions about the abortion trauma.

G. The experience of PAS is not limited to women. Secondary traumatization occurs in men, siblings of the aborted child, extended family members, and health care providers involved with abortion.

H. The literature on pregnancy loss, and postpartum stress reactions in general, as well as that related to attachment and bonding during pregnancy, is informative and often parallels post abortion stress reactions.

III. Summary of Findings

A review of 239 studies on the psychological aftermath of abortion was conducted. Review articles and individual case reports were excluded from analysis. Thirteen control group studies were meta-analyzed. A systematic analysis was conducted on 32 prospective uncontrolled studies and 30 retrospective uncontrolled studies.

A. It is the conclusion of this report that negative psychological after-effects of abortion exist, that they exist on a continuum from mild to severe, and that they can be the basis of a diagnosed post traumatic disorder identified as Post Abortion Syndrome.

B. Furthermore the authors note that the conclusions often drawn from the existing research (i.e. that abortion has few if any psychological risks), is at variance with the findings of this report.

C. The studies reviewed in this report reveal the following converging tends:

1. The literature on abortion's aftermath is largely flawed both in design and methodology.

2. Meta-analysis of the best investigations (i.e., controlled studies), supports the position that post-abortion women demonstrate more negative psychosocial sequelae than do control group women who deliver.

3. There is preliminary evidence to suggest that investigations exhibiting the least methodological sophistication (i.e. more flaws) are more likely to report the highest incidence of positive emotional status post abortion.

4. The present analysis suggest that some 55,000 women will be predicted to experience negative psychosocial sequelae each year if abortion were elected, and an additional 10,000 women electing abortion would be predicted to be hospitalized for psychiatric reasons, relative to those women electing term delivery.

5. That all psychological studies of abortion evidence some negative sequelae for at least a proportion of those women studied.

6. That the clinical literature, and experience with post-abortion trauma is more convergent than divergent in the discovery and formulation of PAS.

7. In addition, the type of error typically found in the many studies on this topic under-represents the incidence of negative responses to abortion. Attrition has been particularly problematic in these studies. In abortion research, attrition may certainly be associated with poorer adjustment, rather than adaption. If that is true, then the majority of the date currently available more likely under-represent the extent of the negative psychological aftermath post abortion. In addition, this tendency in the research leads to an unfortunate misrepresentation of the most severe problems, which in turn is most detrimental to the women who are suffering and at risk.

TABLE 1

Adverse Psychological, Psychosocial and Social Effects of Induced Abortion (By Year)

Researcher(s)	Date	Major Findings
Jansson	1965	An analysis of numerous major studies, i.e. Ekblad (1955), Aren & Amark (1957), Hultin & Ottosson (1962), Lindberg (1948), Hook (1963), Jansson (1963) and Freundt (1964), showed mental insufficiencies strikingly more common after induced abortions than other abortions or delivery. Induced abortion adjudged fairly ineffective as a psychiatric therapeutic means.
Bracken and Suigar	1972	Self-reported negative abortion reactions were associated with being unmarried, young and lacking support from partner and parents.
Osofsky and Osofsky	1972	16% of abortion patients were judged unhappy and 25% expressed guilt.
Kaltreider	1973	Reported on the increased emotional difficulties in midtrimester abortion patients, noting that those women who perceived the fetus as a human being, i.e. baby, felt more guilty or sad.
Ewing and Rouse	1973	19% of post-abortion patients expressed immediate negative reactions, especially if there was a prior history of emotional disturbance.
Moore-Caver	1974	Review of abortion literature found severe guilt in 2 to 23% of patients.
Blumberg, Golbus and Hanson	1975	Selective abortions for genetic defects produced depression in 92% of women and 82% men and had severe psychological effects on families. Negative effects for selective abortions far greater than for delivery of stillborn.

TABLE 1—Continued

Researcher(s)	Date	Major Findings
Lask	1975	Of 50 abortion patients, 32% had adverse outcomes, reporting moderate to severe feelings of guilt, regret, loss and self-reproach.
Greenglass	1976	12% of aborted women experienced negative psychological reactions with 3% attempting suicide. Psychiatric patients pre-abortion were three times as likely to require therapy post-abortion.
Kent	1977	Abortions in patients' histories were major precipitants in seeking psychotherapy.
Gerrard	1977	Sexual inhibition and guilt was found to be significantly higher for women who have undergone abortions than for nonpregnant women.
Belsey, Greer, Lal, Lewis and Beard	1977	An emotional attitude study of 360 women before and three months after first trimester abortion revealed 161 women displaying one or more features of emotional disturbance. Degree of adjustment before pregnancy was the dominant influence and major factor in predicting emotional disturbances.
Bracken	1978	15% of the sample experienced a difficult abortion decision, anxiety, depression and pain.
Spaulding and Cavenar	1978	Reported significant post-abortion guilt, psychoses, consternation and anniversary reactions.
Brewer	1978	20% of sample reported negative psychic trauma from induced abortion.
Kumar and Robson	1978	119 primiparae were interviewed during the 12th and 36th week of pregnancy. In a significant proportion of these expectant mothers there was an association between depression and anxiety early in pregnancy and a previous history of induced abortion, suggesting a reactivation of mourning which was previously suppressed.

TABLE 1—Continued

Researcher(s)	Date	Major Findings
Mester	1978	Induced abortion is a stressing experience and for some women may be traumatic. Psychotherapists may be ignoring or minimizing the importance of the abortion experience for certain kinds of patients in pain.
Morrissey and Schuckit	1978	Problem drinkers and secondary alcoholics were more likely to have experienced an alcohol-related problem subsequent to an abortion.
Liebman and Zimmer	1979	Reported 24 immediate and long-term post-abortion abreactions affecting self image, relationships, and future coping abilities.
Proud	1979	Women who have aborted reported lower total self concept including moral ethical self, physical self perspective, social self and were significantly more defensive than those not aborting. In addition, post-abortion women had higher neurotic scores and lower personality integration. In short, in all areas except personal self, aborting women reported lower levels of self concept.
Somers	1979	Of 597 Denmark women, aborting women under 30 exhibited higher psychiatric admission rates than did women of this age in general. Teen aborters had the highest rate of psychiatric admission (2.9 times the rate of teenagers in general).
Adler	1979	Abortion is a stress experience. A sense of loss influences stressful, negative emotions. Responses to the experience will be a function of the nature and meaning of the pregnancy to the individual, her defensive and coping style, and her social environment.
George	1980	Women who sought abortions scored higher than controls on neuroticism and manifest anxiety.

TABLE 1—Continued

Researcher(s)	Date	Major Findings
Freeman, Rickels, Huggins, Garcia and Polin	1980	Study of 413 women revealed elevated stress levels prior to abortion, particularly depression, anxiety and somatization, and after abortion, *repeat* aborters continued to have significantly higher emotional distress scores in interpersonal relationships.
Ashton	1980	A study of 64 women after eight weeks and 86 women after eight months revealed short-term psychiatric disturbances, including guilt, regrets and sensitivity to comments about the abortion, and 5% suffered enduring severe psychiatric problems post-abortion.
Cates	1980	Relatively more teenagers than older women suffered anxiety, depression, sadness, guilt and regret.
Gould	1980	A study examining health experiences of Harvard women post abortion revealed post-abortion depression, anniversary reactions, guilt and despair.
David, Rasmussen and Holst	1981	In a nationwide hospital study in Denmark, psychiatric problems were significantly higher in women who had abortions than women who delivered or women in general. Negative post-abortion reaction worse for women not in a relationship.
Tishler	1981	Case studies of two adolescent females who had elective abortions illustrate increased psychosocial stress of adolescent abortion which could include suicide on the anniversary date the fetus would have been born.
Williams and Ventimiglia	1981	To minimize negative post-abortion reaction, women should seek support from significant others, be apprised of procedures, be familiar with alternatives and recognize medical and emotional costs.

TABLE 1—Continued

Researcher(s)	Date	Major Findings
Handy	1982	Women seeking termination demonstrated more psychological disturbance than other women. Few women found the decision to terminate easy.
Baker and Quinkert	1983	Data from 252 women who experienced reproductive problems (including abortion). Depression and increased stress were found which improved as the subjects learned more about the problem and drew closer to their families and others with similar problems.
Cohen and Roth	1984	From a study of 55 women, postabortion stress was displayed at fairly high levels. Evidence revealed a "generalized stress response syndrome." "Avoiders" were found to experience more distress than "nonavoiders."
Bradley	1984	Women who had a prior abortion scored higher on levels of depressive effect in the third trimester of pregnancy and in the postpartum period.
Franco	1984	Women reporting multiple abortions had more often considered suicide and scored higher on borderline personality pathology and depression. 40% of the 71 women studied reported anniversary reactions. Half of the women aborting sought psychotherapy after the procedure.
Gold	1984	At the four-week follow-up, abortion patients had poorer psychological adjustment than maternity patients; married abortion group reported less satisfying relationships with their husbands, and also reported poorer psychological adjustment.
Frank	1985	Morbidity within 21 days after induced abortion which was related to that event was found in 10% of 6105 women who had induced abortions.

TABLE 1—Continued

Researcher(s)	Date	Major Findings
Jorgensen, Uddenberg and Ursing	1985	All women in study who had abortions because of fetal malformation experienced severe psychological trauma and about half suffered long-term inability to cope with their personal crises.
Lloyd and Laurence	1985	A retrospective study of 48 women who had abortions for fetal malformation revealed 77% experienced an acute grief reaction with 46% suffering psychiatric symptoms six months post abortion.
Reardon	1986	Of 230 women studied, majority felt "forced" to have abortion; 83% felt "rushed" to make decision; 71% believed their abortion counselors were biased; 80% suffered chronic negative psychological sequelae; 19% reported suicidal ideation; and 20% reported chemical dependencies.
Selby	1986	Study of 92 women who had past abortions who were treated on an in-patient basis revealed majority had been sexually abused in their past; postabortion delayed reaction common; denial and depression experienced by most women; most had sexual adjustment issues and had experienced primary relationship terminated. Case studies identified post-abortion trauma and unresolved grieving such as denial, anger, bargaining, depression and guilt/shame.
Speckhard	1986	Found abortion a stressor event for most women interviewed and that delayed psychological complications occurred for most of the women studied 5-10 years post abortion. 85% were surprised by the intensity of their negative emotional reactions. 81% felt victimized by their abortions.

TABLE 1—Continued

Researcher(s)	Date	Major Findings
Wall	1986	Examined 34 women post abortion. Majority reported chronic emotional problems in the abortion aftermath, including guilt, depression, alcohol and drug abuse, difficulty in relationships, and anxiety in subsequent pregnancies. 26% reported making some suicidal gesture since their abortion.
Hittner	1987	Of 217 women studied, 30% reported one previous abortion. Women with children are more likely to be negatively affected by abortion. Delayed grief was found and nearly 1/3 reported post-abortion unhappiness. "The findings of this study should indicate to mental health counselors that women who choose to have an abortion are more likely to be depressed and lonely than are those in the general population, both before and immediately after the procedure. These findings raise questions about the beliefs that only a few women experience post-abortion emotional difficulties."
Lyons, Larson, Huckeba, Rogers and Mueller	1988	A systematic review of research on post-abortion psychological sequelae concluded that all studies suffer from significant methodological shortcomings but did reveal numerous studies showing negative psychological effects of abortion.
Ney	1988	A survey of psychosocial effects of abortion revealed no psychiatric indications for therapeutic abortions. Short and long term medical and psychiatric complications to abortion illustrate harmful effects of elective abortions.

TABLE 2

Adverse Familial Effects of Induced Abortion

Researcher(s)	Date	Major Findings
Calef	1972	Clinical study suggests post-abortion anxiety and disruption of marital sexual relations.
Perez-Reyes and Falk	1973	15% of post-abortion adolescents expressed adverse feelings of depression, guilt, anger and anxiety, some of which were related to family tensions.
Cavenar, Maltbie and Sullivan	1978	Described psychiatric sequelae of abortion in potential grandparents, intrapsychic conflict in children whose mother aborted a pregnancy known to them, and other family members. Case studies show significant physical and emotional sequelae from therapeutic abortions not attributable to environmental changes or other stresses. Case reports highlight post abortion psychogenic problems for some women for twenty years after the procedure.
Ney	1979	Outline of eight methods of how an increasing rate of abortion is leading to an increasing rate of child abuse. Evidence indicates that post-abortion depression hinders mother-infant bonding in a subsequent pregnancy whereas no evidence indicates elective abortions will reduce prevalence of child abuse.
Plattner	1979	Nearly half of 150 women who elected abortion ended their relationships with the putative father.

TABLE 2—Continued

Researcher(s)	Date	Major Findings
Deutsch	1982	Studied 96 pregnant teenagers. Never pregnant adolescents manifested significantly higher measurers for self-esteem than did first time and repeat abortion subjects. Repeat abortion adolescents showed significantly more signs of instability, personality conflict and sex guilt than the never pregnant group. Teen aborters were more likely to come from families with father absent, marital conflict, poor patterns of communication, family enmeshment or disengagement, and to have lower self concepts.
Ney	1983	Children who have siblings terminated by abortion may have similar psychological conflicts to those children who survive disasters or illness which kill another sibling. Unresolved guilt, fear of parents, obsession to please parents, latent hostility can all be signs of psychological effects of "abortion survivors."
Furlong and Black	1984	Young children may experience particular difficulties in coping with complex information of genetic indicated abortions and may show negative reactions to parents' distress and maternal absence.
Mattinson	1985	Unable to mourn the loss of the child at the time of the abortion, parents show a delayed grief reaction. It may be mild but persistent, or it may occur in more extreme form many years later when subsequent loss of a different nature triggers repressed grief. Many of the married couples in this clinical report are still troubled by an abortion of many years ago, and were largely unaware at the time of the abortion of the intensity of their feelings and the personal meaning of this death experience.

TABLE 2—Continued

Researcher(s)	Date	Major Findings
Rue	1985	Because of the basic inequality between the partners in an abortion decision, future marital skills and communication may be severely handicapped and restricted. "Some men view abortion as a destruction of man's seed—a death event."
Ney	1987	Parents have difficulty bonding with surviving children if the neonatal losses are not mourned appropriately, especially if the loss comes from elective abortion. Counselors must help parents and surviving children go through grieving process for neonatal deaths.
Reardon	1988	Summary of case reports of children from one year up to 21 years old suffering negative effects from mother's induced abortion. Children display fear that mother is "agent of death," hostility and agression toward siblings and peers, feeling neglect, anorexia, depression and withdrawal if not properly treated.

Senator METZENBAUM. There is a roll call on, and the committee will stand in recess for approximately 10 to 15 minutes.

[The committee recessed at 10:45 a.m., and resumed at 11:45 a.m.]

Ms. SIGNS [committee counsel]. Because of pending Senate business, the Senator is not going to be able to return nor are any other Senators available to chair out the remainder of the hearing.

What we are going to do is dismiss the second panel, and we will submit to you questions in writing and you can submit responses to for the record.

I apologize for the long delay and for the inconvenience that it has created, and I think it also doesn't exactly lead to the most consistent record, but hopefully you will be able to answer the questions in full in writing.

Thank you for coming all this way.

What we will do is invite the third panel to present their testimony, and then we will submit again questions in writing for them.

The third panel consists of Dr. Jocelyn Elders, director of the Department of Health for the State of Arkansas, from Little Rock, and Ms. Carol Everett, who is director of the Life Network, from Dallas, TX.

I want to thank you both for coming a long way to be here with us this morning, and I apologize for the circumstances, but we are very anxious to hear your testimony.

Dr. Elders.

STATEMENTS OF DR. JOCELYN ELDERS, DIRECTOR, DEPARTMENT OF HEALTH FOR THE STATE OF ARKANSAS, LITTLE ROCK, AR; AND CAROL EVERETT, DIRECTOR, LIFE NETWORK, DALLAS, TX

Dr. Elders. Thank you. Good morning, Kelly, and to all the members of the Labor and Human Resources Committee who are unable to be here, I am Dr. Jocelyn Elders. I am Director of the Arkansas Department of Health.

I am a pediatrician. I am a member of the American Pediatric Society, the Society of Pediatric Research, and I am the Secretary-Treasurer of the Association of State and Territorial Officers.

I am here representing public health concerns and many women in America as it relates to the Freedom of Choice Act.

This Act requires States to adopt a very important principle in their regulation of abortion services, which is that State may regulate abortion services, but only in ways that are medically necessary to protect the life or health of the pregnant woman.

As a State health officer, my primary concern is the health and well-being of all of our citizens. In the 17 years that abortion has been legal nationwide, it has had an important and positive public health effect. Abortion is extremely safe. Abortion-related deaths have fallen from 17 percent of maternal deaths to almost 3 percent, and less than half of one percent of abortion patients are hospitalized.

Abortion is 11 times safer that childbirth and twice as safe as a shot of penicillin. More women are having abortions earlier, when

they are safer. Many families at high risk of genetic defects are willing to have a family now, only because of the option of a safe, legal abortion.

Many types of abortion regulations have been proposed. Some of these proposals appear reasonable and medically necessary. Others serve no public health purpose, while others even pose a public health threat.

Although each proposal shares a common outcome, they all have the problem of reducing the number of abortion providers, increasing the cost of the procedure, necessitating long-distance travel to receive abortion services, or imposing administrative obstacles, all designed to cause delays. Delays increase risk; they increase cost, and they decrease providers.

Some of the examples of proposals that are necessary include: provisions for licensing and oversight of physicians, written protocol for medical procedures, provisions for emergency care in the event of complications, proper medical screening and health histories of patients, and guidelines of basic sanitation.

However, not all licensing requirements further such legitimate public health concerns. An example of these are those that try to make clinics functional equivalents of small hospitals, such as corridor widths, central screening desks, sex-segregated locker rooms, elaborate ventilation systems. No evidence exists that such requirements promote patient safety.

Let's talk about waiting periods. These do little to foster informed decisionmaking. They only cause serious problems for women by creating increased cost of the abortion procedure and causing delays. Ninety percent of women coming in for abortions have already consulted someone prior to making the decision. This problem is especially acute in rural States such as Arkansas, where women are forced to travel great distances for the extra visit to the abortion clinic that does nothing to protect her health.

In the area of informed consent, this is a fundamental principle of medical practice. Unfortunately, the so-called informed consent laws that have been proposed regarding abortion are designed, according to the U.S. Supreme Court, "not to inform the woman to obtain her consent, but rather, to persuade her to withhold it altogether."

There is no health-related justification for additional State informed consent requirements.

Requirements that all abortions after the first trimester be performed in hospitals serve no public health purpose. Data from the CDC shows that abortions may be performed as safely in nonhospital settings until the middle of the second trimester for women who are not at high risk. The American College of Obstetrics and Gynecology considers abortions outside of hospitals appropriate during the first 14 weeks of pregnancy.

Limiting abortions to hospitals would greatly limit access. Less than half of all hospitals in which early abortions are performed will perform abortions after the first trimester. In nine States, no in-hospital, second trimester abortions were performed in 1985.

Because abortions in hospitals are two to three times as expensive as abortions in nonhospital settings, a hospital requirement

would make abortions much more expensive, even prohibitive to some low-income women, and cause additional delays.

It would also markedly alter the education of young physicians. A ban on abortions in public hospitals could also markedly decrease the number of low-income women having abortions, especially minority women, as half of all patients who have abortions in hospitals are from minority groups.

In conclusion, as a public health issue, there is no question that early abortion is a medically safe procedure. It has become an important component of a comprehensive public health strategy to protect and promote the health of women because we as a Nation have refused to do those things necessary to prevent unplanned pregnancy. We refuse to invest in good family planning programs and contraceptive research. We refuse to invest in early childhood education for our children at highest risk for an unplanned pregnancy or subsequent abortion. We have refused to support comprehensive health education, which we know is the groundwork for wellness. We have refused to support families and teach our young men responsibility. We have denied access to our children in schools because of all the health problems and social problems which are impacting their health, such as drugs, alcohol, homicide, suicide and teen pregnancy.

Senator METZENBAUM. Thank you, Dr. Elders.

Dr. Elders. Thank you.

[The prepared statement of Dr. Elders follows:]

PREPARED STATEMENT OF JOYCELYN ELDERS

Good morning Senator Metzenbaum, and members of the committee on Labor and Human Resources, I am Joycelyn Elders, director of the Arkansas Department of Health. I am here representing the Association of State and Territorial Officers, the public health concerns and many women in America.

I am pleased to be here to discuss the Freedom of Choice Act (FOCA), which would require states to adopt a very important principle in their regulation of abortion services: This act would allow states to regulate abortion services, buy only in ways that are "medically necessary to protect the life or health of the pregnant woman."

As a state health officer, my primary concern is the health and well-being of the residents of my states. In the 17 years that it has been legal nationwide, abortion has had an important, and positive, public health effect.

- Abortion is extremely safe. Abortion-related deaths have fallen from 17 percent of maternal deaths to almost 3 percent and less than one half of one percent of abortion patients are hospitalized. Abortion is 11 items safer than childbirth and safer than a shot of penicillin.
- More women are having abortions earlier when they are safer. The percent of abortions at or below 8 weeks rose from 20 percent in 1970 to 53 percent in 1985; more than nine in 10 abortions are performed in the first trimester.
- Abortion was the single most important factor in the significant decrease in neonatal mortality between 1964 and 1977; abortion was responsible for a reduction of 1.5 neonatal deaths per 1000 live births among white and 2.5 per 1000 live births among blacks.
- Many families at high risk of genetic defects are willing to become pregnant only because of the option of abortion. Further, abortion has reduced the number of children afflicted with severe defects; the number of Down's syndrome infants in Washington state in 1976 was 64 percent lower than it would have been without legal abortion.

Many types of abortion regulation have been proposed. Some of these proposals appear reasonable and medically necessary at first. In reality, however, many serve no public health purpose. And some even pose a public health threat. Although each proposal differs, many would share a common outcome. Whether by reducing the number of abortion providers, increasing the cost of the procedure, necessitating long-distance travel to receive abortion services or imposing administrative obstacles -- these measures cause delays.

- Delay increases risk. Abortion at 11 or 12 weeks are three times more dangerous for the woman than at or before eight weeks. Risks rises further later in gestation. Morbidity follows same pattern.
- Delay increases cost. Average cost of clinic abortion is $231 at eight weeks but $400 at 16 weeks. Increases costs cause additional delay.
- Delay reduces number of providers. One-third of abortion clinic will not perform abortions after 12 weeks; three-quarters of abortion providers will not perform abortions after 16 weeks. Inability to find providers can cause even further delay.

Most freestanding abortion providers in the United States, according to a 1981 study, are licensed by some state, county or local government. When clinic licensing requirements serve to protect the health of the pregnant woman, they serve a legitimate public health goal. However, not all licensing requirements further such a legitimate purpose.

- Examples (but not an exhaustive list) of state requirements that are designed to protect the health of the abortion patient are:
  - provisions for the licensing and oversight of physicians (State medical boards -- peer-review panels that are charged with ensuring that medical care is delivered safely and in a manner consistent with the standards of the profession -- often have wide latitude to see that unsafe practitioners are unable to practice medicine in a state.);

- written protocol for medical procedures;
- provisions for emergency care in the event of complications such as requiring emergency equipment for such procedures as cardiopulmonary resuscitation, transporting and admitting patients to local hospitals under the care of a physician familiar with abortion care and establishing 24-hour emergency telephone numbers;
- requirements for proper medical screening and health histories of patients; and
- guidelines for basic sanitation.

• Abortions are as safe in clinics as in hospitals. Therefore, licensing requirements that turn clinics into the "functional equivalent of small hospitals" are unnecessary and serve only to increase the cost to the facility, and ultimately the patient. Examples of such unnecessary requirements are those that mandate specific corridor widths, central screening desks, sex-segregated locker rooms and elaborate ventilation systems. No evidence exists that such requirements promote patients' safety.

Waiting periods do little to foster informed decision-making, but do cause serious problems for women by increasing the cost of the abortion and creating delays that raise the health risks of the procedure. This problem is especially acute in rural states such as mine,where women could be forced to travel great distances for an extra visit to the abortion clinic that does nothing to protect her health.

• Women having abortions have thought seriously about their decisions. Patients give an average of four reasons for their abortions. Nine in 10 women consult with at least one other person.

• One study of abortion patients who had complied with a waiting period found that 93 percent were unable to name a single benefit.

- Two-thirds of patients said the waiting period caused problems such as mental anguish, transportation and logistical problems and additional physical discomfort.
- Delay may be much more than 24-48 hours for some women:
  - six percent of abortion patients have to cross state lines
  - one-third of abortion patients cross county lines;
  - 68 percent work and have to arrange additional time off;
  - 42 percent have children and may have to arrange child care; and
  - 31 percent are in school and would miss additional classes

Informed consent is a fundamental principle of medical practice. Unfortunately, the so-called informed consent laws that have been proposed are designed, according to the Supreme Court, "not to inform the woman to obtain her consent but rather to persuade her to withhold it altogether."

- Informed consent requirements are embodied in the basic standards of the medical profession and the organizations to which abortion providers belong. These codes require physicians to tell women about the alternatives to abortion and to obtain informed consent before performing an abortion. There is no health-related justification for additional state informed consent requirements.
- Requirements that mandate a discussion of excessive risks or risks that are not germane to a particular patient serve no legitimate purpose. For example, a discussion either of the risks of a later abortion or of fetal development late in pregnancy is irrelevent to a woman having an abortion at 8 or 9 weeks.
- Provisions are inherently biased if they require only a discussion of the risks of abortion and not the risks of pregnancy and childbirth.

Requirements that all abortions after the first trimester be performed in hospitals serve no public health purpose. According to the CDC, abortions may be performed as safely in non-hospital settings at least until the middle of the

second trimester for women who are not at high-risk. The American College of Obstetrics and Gynecology (ACOG) considers abortions outside of hospitals appropriate during the first 14 weeks of pregnancy.

- Limiting abortions to hospitals would greatly limit access. Less than half of all hospitals in which early abortions are performed will perform abortions after the first trimester. In nine states, no in-hospital, second-trimester abortions were performed in 1985. Locating a hospital provider could result in a substantial delay.
- Because abortions in hospitals are typically two to three items as expensive as abortions in non-hospital settings, a hospital requirement would make abortions much more expensive, even prohibitive to some low-income women, and cause additional delay.

A ban on abortions in public hospitals, even if the woman paid the entire cost of the procedure herself, could easily be written to preclude abortions in virtually any hospital in the nation, since all hospitals have some involvement with government. Such a ban would have a disproportionate effect on low-income women, would make abortions unavailable to some women and cause serious delays.

- Since medical education in this country relies on hospitals, a ban on abortions in hospitals would seriously decrease the number of physicians trained and experienced in performing abortions. Adequate training and experience is closely related to safety.
- Forty percent of women having abortions in hospitals, compared with only 30 percent of patients in clinics, have annual incomes below $11,000. Half of all patients who have abortions in hospitals are members of minority groups, compared with less than one-third of clinic patients.
- A prohibition of abortions in hospitals is tantamount to prohibiting abortions in cases of fetal defect, which almost always are performed in hospitals.

- In one of three U.S. counties with an abortion provider, the only provider is a hospital; in 13 percent, the only provider is a public hospital. Women in these counties would be forced to travel long distances, and probably delay their procedures, or carry their pregnancies to term.

Conclusion:

Early abortion is a medically safe procedure. It is an important component of a comprehensive public health strategy to protect and promote the health of women. The Freedom Of Choice Act takes a balanced approach toward the abortion issue. Appropriately, and necessarily, it places priority on the health of women, which is the standard by which any effect to regulate abortion must be measured.

Senator METZENBAUM. Ms. Everett, Director of Life Network in Dallas, Texas, we are happy to have you with us this morning.

And before going forward, I want to apologize to the four previous witnesses on the previous panel. A vote was on the floor of the Senate; it was a matter in which I had major involvement; there were a number of problems that developed thereafter, and I had to remain on the floor and participate in some negotiations.

So I apologize; I did not mean to be rude, and we will be submitting questions in writing to those witnesses. But it was not because I was indifferent to the substance of their testimony.

Ms. Everett, please proceed.

Ms. EVERETT. Thank you, Senator.

I come from a little different experience. I had an abortion in 1973 simply because a third child was inconvenient, and in an attempt to resolve my inner conflict with that decision, I became involved in the abortion industry to the point of owning two abortion clinics in the Dallas-Fort Worth area from 1977 through 1983.

Each time I sold another woman an abortion, I justified my own. I was involved in over 35,000 abortions, and in the last 2 years I did own two clinics. The last month in the abortion industry, we did 545 abortions. My commission was $25. That means my income that last month was $13,625. I planned in 1983 to make between $250,000 to $260,000, and the next year we were going to expand to a total of five clinics, where we would do 40,000 abortions, and I would make $1 million.

The State of Texas had no reporting requirements until 1986, and I am very happy to report that I was instrumental in helping to put that in place. We did not report any of our abortions to the Centers for Disease Control or to the Alan Guttmacher Institute, and we certainly did not report our complications.

So I take a little—when someone says abortion is 11 times safer than childbirth that is because, just as we did, I wonder if the abortionists report their statistics.

The last 18 months of my involvement in the abortion industry, we had one major complication for each 500 abortions. That means once a month we had a woman—and let's define "major complications"—who either died or had a hysterectomy, or her uterus was perforated and her bowel pulled through her vagina, which of course means a colostomy, or urinary tract repair.

Senator METZENBAUM. Excuse me. I must take an urgent call. Kelly Signs, my committee counsel, will preside in my absence.

Ms. EVERETT. OK.

Again, not one of our complications was reported; not one of those complications ever appeared in the newspaper, and not one lawsuit was filed.

Unfortunately, the killing of women still goes on inside the abortion industry today, and I have with me, and I hope you have a copy of my testimony, a copy of the death certificate from an abortion on April 27, 1990. This 28 year-old mother had a 10 year-old, an 8 year-old and a preschooler, was divorced and pregnant for the fourth time. She went in and had her abortion completed by 8:30 a.m. that morning, went home, discharged, everything was supposedly fine. She was bleeding profusely, and she called the clinic and told them how heavily she was bleeding. They told her not to

be concerned. She called again, was again reassured, and by 6:01 p.m. that evening, this woman died from that so-called safe, legal abortion.

If you will note, the death certificate says under "Immediate cause", "internal hemorrhage with major blood loss, laceration of uterus from a uterine abortion."

Under "Describe how injury occurred", it says, "Uterine laceration from abortion."

Women die from legal abortion in our Nation.

Out of those 35,000 abortions, not one was for the health or life of the mother. All were for convenience; birth control abortions.

One mother presented with an anacephalic baby verified by five medical doctors, and not one of our doctors would touch that woman.

The recovery room was strategic because we knew that over 40 percent of these women could be resold an abortion. It was important to be friendly because we knew she would be telling her friends how great we were, and she would be coming back for another abortion. And we all worked on a commission, the doctors and myself.

Birth control was dispensed free-of-charge, with no additional medical work up until the woman's two-week checkup. The checkup was free, so we could be certain she was not pregnant. We didn't want her coming back at 20 weeks telling us she was pregnant again. And the Pap smear was for the pills, and it was $10.

We actually sold abortions by finding out the reason the woman wanted not to be pregnant and then explaining how abortion could "take care of her problem." For instance, with minors, we regularly planted the fear, "Wouldn't your parents kill you if they found out you were pregnant?" And of course, the frightened teenager always said "Yes." If she talked about having the baby, we always said, "But what would your parents say?" and she moved toward the abortion experience again.

When asked if it was a baby, we always said it was as glob of tissue, a blood clot, or a piece of tissue—even though we held those little babies' broken bodies in our hands, we never told the woman it was a baby, formed by the time she knew she was pregnant, heart beating 18 days after conception, because she would not have an abortion if she knew the truth.

I now think how we cheapen women by not giving them the true facts—yes, I did tell myself I was helping women.

Abortion is not about choice, rights, rape or incest. Abortion is about money. When a doctor makes one-third to one-half of the fee from $250 to $8,000 per abortion, doing abortions, 10 to 12 first trimester abortions per hour times $75, which is the minimum, equals $750 to $900 per hour. We paid our doctors in cash. We did not keep records of the doctors' income. They were not given a 1099 or a W-2 at the end of the year. Reporting of their income to Internal Revenue Service was left entirely to the discretion of the abortionist. Abortion is about money.

Abortion is a skillfully-marketed product, sold to a woman at a crisis time in her life. She buys the product, finds it defective, wants to return it for a refund, but it is too late. Her baby is dead.

And based on my personal experience, not only is her baby dead, but her other children will suffer from postabortion syndrome, as my 27 year-old and 25 year-old children have; I suffered from postabortion syndrome, and my husband and I were divorced, and our lives were destroyed by that abortion.

I became pregnant when I was 16. I was wrongfully sexually active. And today we would tell that young woman that she could do anything in the world but have that child in a crisis situation. But today, because I chose life, I have a 27 year-old young son with a degree, nine hours short of a second degree, and he is a bank officer.

Ms. SIGNS. Thank you, Ms. Everett.

Ms. EVERETT. Wait a minute. The Senator interrupted; let me finish this story, please.

He is a positive. I have a 17 year-old hole in my life from my abortion. It destroyed us all. We are a postabortive family today.

Thank you.

Ms. SIGNS. Thank you for your testimony.

[The prepared statement of Ms. Everett and additional information submitted for the record follow:]

CAROL EVERETT TESTIMONY BEFORE

LABOR AND HUMAN RESOURCES COMMITTEE

I had an abortion in 1973 because a third child was not convenient. In an attempt to resolve my inner conflict with that decision, I became involved with the abortion industry in the Dallas/Fort Worth, Texas area. For over six years, each time I sold another woman an abortion, I re-justified my own abortion decision.

I was involved in over 35,000 abortions, and the last two years, I was owner/operator of two clinics. My compensation for the daily operation of the clinics was $25.00 for each abortion. The last month in the abortion industry, our clinic did 545 abortions which means my income that month was $13,625. I planned in 1983 to make $250,000 to $260,000, when we expanded to five clinics, we would do 40,000 abortions and I would make $1,000,000.

The State of Texas had no reporting requirement until 1986. We did not report any of our abortions - and certainly not our complications. The last 18 months I was involved in the abortion industry we had one major complication out of each 500 abortions. My definition of a complication is death, (a 32 year old woman died from an abortion at our clinic) hysterectomy, colostomy, or urinary tract repair. Again, not one of our complications was reported to the Center for Disease Control in Atlanta, Georgia, or to the Alan Guttmacher Institute. Not one of those complications ever appeared in the newspaper, and not one lawsuit was filed.

Unfortunately, the killing of women still goes on inside the abortion industry today. I present a copy of a death certificate from an abortion death April 27, 1990. This 28 year old mother of a 10 year old, 8 year old, and a pre-schooler, divorced, pregnant for the fourth time, had her abortion by 8:30 a.m. on April 27, and was discharged. She called the clinic back to report heavy bleeding. She was told not to be concerned, and she was dead at 6:01 p.m. the same day with the description, "internal hemorrhage with major blood loss", "uterine laceration from an abortion" under "Describe how injury occurred", on her death certificate. Women still die from legal abortion.

Out of those 35,000 abortions, not one was for the health or life of the mother. All were for the convenience of the mother: birth control abortions.

One mother presented with an anacephalic baby verified by five medical doctors. That abortion was not done in our clinic.

The recovery room was strategic because we knew over 40% of these women could be re-sold an abortion. It was important to be friendly with the woman because we clearly knew she would be

telling her friends how great we were, and coming back for another abortion. Birth control was dispensed free of charge with no additional medical workup until the woman's 2-week check-up. The check-up was free, so we could be certain she was not still pregnant, but the pap smear for pills was $10.00

Actually, we sold abortions by finding out the reason the woman wanted not to be pregnant, and then explaining how abortion would "take care of her problem." For instance, with minors we regularly said, "Wouldn't your parents kill you if they found out you're pregnant?" Of course the frightened teenager always said, "Yes." If she talked about having the baby, we always said, "Yes, but what will your parents say?" And she moved toward abortion again.

When asked if it was a baby, we always said it was "a glob of tissue", "a blood clot", or "a piece of tissue." Even though we held those babies' broken bodies in our hands, we never told the mother it was a baby, formed by the time she knew she was pregnant, heart beating 18 days after conception, because she would not have an abortion. I now think how we cheapened women by not giving them the true facts. Yes, I too told myself I was helping women.

Abortion is not about choice, rights, rape, or incest. Abortion is about money. When a doctor makes 1/3 to 1/2 of from $250.00 to $8,000 doing abortions, ten to twelve first trimester abortions per hour times $75.00 (minimum) equals $750.00 to $900.00 per hour. We did not keep records of the doctors' income but paid them in cash at the end of the day without a 1099 or W-2 at the end of the year. Reporting of income to Internal Revenue Service was left entirely to the discretion of the abortionist.

Yes, abortion is about money. Abortion is a skillfully marketed product sold to a woman at a crisis time in her life. She buys the product, finds it defective, wants to return it for a refund, but it is too late, her baby is dead.

CERTIFICATE OF DEATH

Reg Dist No 72
Primary Reg Dist No 7201
State File No
Registrar's No 158

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last): SANDRA MILTON
2. SEX: Female
3. DATE OF DEATH (Month, Day, Year): April 27, 1990
4. SOCIAL SECURITY NUMBER: 286-60-0570
5a. AGE (Last Birthday) (Years): 28
5b. UNDER 1 YEAR (Months / Days): 5c. UNDER 1 DAY (Hours / Minutes):
6. DATE OF BIRTH (Month, Day, Year): Feb. 17, 1962
7. BIRTHPLACE (City and State or Foreign Country): Weymoth, England
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☒ No
9a. PLACE OF DEATH (Check only one): HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☒ DOA; OTHER ☐ Nursing Home ☐ Residence ☐ Other (Specify)
9b. FACILITY NAME (If not institution, give street and number): Memorial Hospital
9c. CITY, VILLAGE, TWP., OR LOCATION OF DEATH: Fremont
9d. COUNTY OF DEATH: Sandusky
10. MARITAL STATUS (Married, Never Married, Widowed, Divorced) (Specify): Divorced
11. SURVIVING SPOUSE (If wife, give maiden name):
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Assembler
12b. KIND OF BUSINESS/INDUSTRY: Appliance Mfg.
13a. RESIDENCE - STATE: Ohio
13b. COUNTY: Sandusky
13c. CITY, TOWN, TWP. OR LOCATION: Green Springs
13d. STREET AND NUMBER: 112 N. Broadway
13e. INSIDE CITY LIMITS? (Yes or No): No
13f. ZIP CODE: 44836
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes - If Yes, specify Cuban, Mexican, Puerto Rican, or Other Spanish): ☒ No ☐ Yes
15. RACE - (American Indian, Black, White, Asian, Pacific Islander, Other - Specify): White
16. DECEDENT'S EDUCATION (Specify only highest grade completed) (Elementary/Secondary (0-12), College (1-4 or 5+)): 12

PARENTS

17. FATHER'S NAME (First, Middle, Last): Harold A. Earle
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Davies

INFORMANT

19a. INFORMANT'S NAME (Type/Print): Harold Earle
19b. MAILING ADDRESS (Street and Number or R.D. Number, City or Town, State, Zip Code): 1704 Moore St., Fremont, Ohio 43420

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place): Oakwood Cemetery
20c. LOCATION - City or Town, State: Fremont, Ohio
21a. DATE OF DISPOSITION: May 1, 1990
21b. NAME OF EMBALMER: Roger L. Haubert
21c. LICENSE NUMBER: 6874 A
22a. SIGNATURE OF FUNERAL DIRECTOR OR OTHER PERSON: ► Roger L. Haubert
22b. LICENSE NUMBER (If applicable): 6053
22. NAME AND ADDRESS OF FACILITY: Wonderly-Horvath-Haubert, 425 E. State St., Fremont, OH 43420

REGISTRAR

23a. REGISTRAR'S SIGNATURE: ► Marsha Overmyer
23b. DATE FILED (Month, Day, Year): May 8, 1990
24a. SIGNATURE OF PERSON GIVING DEBIT: ►
24b. DIST NO
27. DATE PERMIT ISSUED

CERTIFIER

25a. CERTIFIER (Check only one):
☐ CERTIFYING PHYSICIAN — To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ CORONER — On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place, and due to the cause(s) and manner as stated.
25b. TIME OF DEATH: 6:01 P. M
25c. DATE PRONOUNCED DEAD (Month, Day, Year): April 27, 1990
25d. WAS CASE REFERRED TO CORONER? ☒ Yes ☐ No
26a. SIGNATURE AND TITLE OF CERTIFIER: ► Samuel R. Lowery, M.D.
26b. LICENSE NUMBER: 20991
26c. DATE SIGNED (Month, Day, Year): May 2, 1990
26d. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (If other than certifier): Samuel R. Lowery, M.D., 2323 Countryside Dr., Fremont, Ohio 43420

CAUSE OF DEATH

PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Add additional lines if necessary.

Immediate cause (final disease or condition resulting in death): a. Internal hemorrhage with major blood loss
Due to (or as a consequence of): b. Laceration of uterus
Due to (or as a consequence of): c. Uterine abortion
Due to (or as a consequence of): d.

Sequentially list conditions, if any, leading to the immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28. WAS AN AUTOPSY PERFORMED? ☒ Yes ☐ No
29. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? ☒ Yes ☐ No

30. MANNER OF DEATH: ☐ Natural ☐ Accident ☒ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined
31a. DATE OF INJURY (Month, Day, Year): April 27, 1990
31b. TIME OF INJURY: 8:30A. M
31c. INJURY AT WORK? ☐ Yes ☒ No
31d. DESCRIBE HOW INJURY OCCURRED: Uterine laceration from an abortion
31e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify): Abortion clinic
31f. LOCATION - Street and Number or R.D. Number, City or Town, State: Monroe St., Toledo, Ohio

AFFIDAVIT OF CAROL N. EVERETT

STATE OF TEXAS)
)
)

BEFORE ME, the undersigned, a Notary Public in and for the State of TEXAS, on this day personally appeared Carol N. Everett, who upon being duly sworn stated as follows:

My name is Carol N. Everett. My address is 17430 Campbell Road, Dallas, Texas 75252.

After my own abortion February 19, 1973, I realized I had murdered my own son, and found that though I could not share my own abortion experience, I could tell other women what a great choice abortion would be for them. As I evolved into the abortion industry, I found abortions an easy product to market. My arrangement with the clinic was a commission of $25.00 per abortion. I worked on a straight commission basis. My last month in the abortion industry, our two clinics accomplished 545 abortions which resulted in an income of $13,625 that month for me.

I was a hands-on operator, involved in employee training in all capacities. We rotated eight doctors through our two clinics on a seven day-a-week schedule. An unlicensed doctor did our sonograms and laminaria insertions. Texas does not have a law stating that abortion must be performed by a physician.

The telephone counselors were skillfully trained to get the women in the clinic.

Our patients' demographic information such as age, address/area, marital status, referral source, income range, date appointment was booked, date abortion was completed, gestational age, no show statistics, if she was not pregnant, or too far along, was all on computer. The percentages were accurately and monthly reported for each employee answering the telephone.

These statistics clearly reflected that the sooner an appointment was made, the higher the ratio of completed abortions. Our conclusion was that the shorter the period of time a woman had to consider her abortion, the more likely she was to have an abortion. We felt that the shorter time frame gave the woman less time to discuss her decision with family and friends, which resulted in a decision made hastily to actually hide her pregnancy from her support system.

Since the consent of the spouse or parents was not considered relevant to marketing techniques, we did not keep that statistic; however, I remember many women's concern of how to keep the abortion a secret from their families in the week following procedure.

Our counseling sessions were actually to calm the woman down, soothe her fears, and not to actually offer any alternatives but abortion. I trained our counselors to "sell" our product. We never discussed any alternatives but abortion unless she mentioned one. We asked each woman why she was choosing abortion, and then agreed that this was the best choice for her. If she started to move away from the abortion decision, we reminded her "your parents will find out, and you do not really want to deal with that, do you?" and moved her back to the abortion decision.

Each woman asked at least two of the same questions. The first question is "Is it a baby?" Even though clinic personnel call it "a glob of tissue", "two tablespoons of matter", a "blood clot," or "a piece of tissue", I believe women know their body is making changes to accommodate the baby; however, in a crisis pregnancy, we want to believe that it is nothing - certainly not a baby. And this pregnancy expert, the abortion clinic counselor answers, "No, it is not a baby. It's a glob of tissue." I have never heard or been aware of one counselor answering a woman that, "Yes, it is a baby."

I worked in the procedure area and cleaned the instruments after the abortions. I have held those babies' little bodies and organs in my hands. Not one of those babies was hollow. All had organs and a tissue check had to be completed, as early as an abortion could be performed, to be certain all the body parts were there.

As a post-aborted mother, I wish I had been told that at ten weeks my son was completely formed, heart beating 18 days after conception with brain waves 42 days after conception. I would not have had an abortion.

The second question is, "Does it hurt?" Our answer was "Your uterus is a muscle. It is a cramp to open it, a cramp to close it, so you will feel a slight cramping sensation similar to your monthly menstrual cramps." Women were told that "abortion is safer than childbirth and ten times easier" even though we knew that childbirth and abortion statistics are reported together to the Center for Disease Control so it is impossible to say that abortion is safer than delivery.

My personal experience in the abortion industry is that in the last 18 months (of my involvement), we experienced one major complication per month, or one major complication out of every 500 patients. I define a major complication as death, hysterectomy, colostomy due to perforation of the uterus resulting in bowel injury, perforation of the uterus, urinary tract repair due to

perforation of the uterus and injury to the urinary tract. Although the records were not kept to separate them by gestation, over 75% of the major complications were for women 24 weeks or over. The woman is dealing with her new problem, her family and their emotions, and does not call the media. The abortion industry has a built-in cover-up because of the social stigma attached to abortion.

Not one of our complications was reported to the Center for Disease Control or to the National Abortion Federation.

With two of the physicians, my job was to hold the baby still for the second and third trimester abortions. We used the D&E method, the dilation and evacuation. With large forceps, the doctor pulls the baby apart inside the mother's womb, and reconstructs it outside the uterus to be certain all body parts have been removed. No labor for the mother and no live births. My job was to tell the doctor where the parts were, the head being of special significance because it is the most difficult to remove. The head must be deflated, usually by using the suction machine to remove the brain, then crushing the head with large forceps. Psychologically, the doctors always sized the baby at 24 weeks; however, we did an abortion on one baby I feel was almost full term. The baby's muscle structure was so strong that it would not come apart. The baby died when the doctor pulled the head off the body.

I saw many babies aborted over 20 weeks, that could have lived outside of their mother's womb.

We had a token R.N. on staff, but kept her out of the procedure area for the most part.

Our staff was trained to adapt to each doctor, meeting the needs of the doctor regardless of the term of the pregnancy.

We routinely re-used the currettes, gas sterilizing them, even though the sterile package clearly states "STERILE - Use once and discard. Contents of unopened or undamaged package guaranteed sterile." (EXHIBIT A)

The tubing for the suction machine was reused from patient to patient, using only one tube per procedure room per day, even though it was also designed for only one use.

On a busy day, when we were rushing the women through, using two or three doctors, instruments were only "flashed". A term which means that rather than maintaining the instruments at a temperature considered high enough to sterilize them for twenty minutes to insure sterilization, the autoclave was kept as hot as possible, instruments were placed in the autoclave, the temperature raised to the level considered high enough to sterilize for <u>seven</u> minutes only, steam released, instrument sometimes cooled in the refrigerator, or even given to the physician so hot that he had to

use gauze sponges as a hot pad to dilate the woman's cervix to do the abortion.

In order to insure sterility, instruments should not even be touched when the wrapping paper is still wet from the steam. This was routinely violated in an effort to keep turning instruments so each doctor could do ten to twelve first trimester abortions per hour. Second and third trimester abortions were considered to take twenty to thirty minutes each to remove all the body parts, placenta and blood. I saw one abortion procedure last four hours with the woman awake.

In a hospital environment, a doctor writes orders for his patient, the room is completely scrubbed and cleaned between patients. All instruments are sterilized completely, and complete new sets brought in for each case. The woman is sedated, prepped, anesthetized, and the physician is expected to cover his hair, mask, do a surgical scrub (on his hands and forearms), gown with a sterile gown and sterile gloves.

The physician completes the abortion procedure, and then is expected to go to the recovery room, check his patient, write follow-up orders, and speak with the patient's family while the operating room is re-cleaned and the entire procedure starts over. Time elapsed: roughly one hour.

In a free standing clinic, only the regulations the state, city and physician imposed on personnel are followed. But, because of the 40 plus percent repeat rate of abortions, the clinic staff and doctors strive to keep the patient satisfied so that she will return for her repeat abortion, and share with her friends how accommodating the clinic is.

Thus on a busy day, the two to three doctors working in the clinic - optimally two teams of two women work with each doctor. Team #1 sets up woman #1 and the doctor does that abortion, while across the hall, team #2 sets up woman #2 so that when the doctor finished abortion #1, he can run across the hall to do abortion #2. While he is doing abortion #2, team #1 takes woman #1 to the recovery room, leaves her with that attendant, then rushes back to "turn the room." The table paper is pulled down, an underpad is put on the table, wipe the visible blood off, take the baby in the bottle to Central Supply, put the baby into a strainer, wash the blood off with water, pour the baby on the underpad and number it so that the doctor can check to be certain all the body parts are present. If a body part is missing, it is necessary to repeat the abortion procedure.) As early as an abortion can be done, it is necessary to do a tissue check. The physician is responsible and only sends it out when questioning something in order to keep the cost down. Lab fees vary for tissue analysis.

The blood is then washed out of the bottle, bottle replaced in the machine, rubber stopper put in the bottle mouth, tubing re-applied, and the instruments used in the first procedure replaced.

Woman #3 is brought in, placed on the table, and we allowed her counselor, usually the one who booked her on the telephone to remain with her to keep her quiet. Our experience was that if one patient screamed, it upset the entire day so we strived to keep each patient quiet as possible.

When the doctor finished abortion #2, he runs back across the hall to do abortion #3. The physician in our clinics did not routinely scrub their hands and forearms before the next abortion procedure. The physician does re-glove, using sterile gloves, inserts the speculum designed to hold the vagina open so he can see to work, cleans the cervix off with Betadine, a pre-surgical scrub, numbs the cervix with Xylocaine, similar to Novocaine the dentist uses to numb your gums when your teeth are worked on, and then dilates the cervix, starting with very small dilators, slowly graduating in size until the cervix is large enough to accommodate the cannula. Prior to Roe vs. Wade, an abortion was done with a knife shaped like a hollow spoon called a curette. The curette scraped the baby off the wall of the uterus, then a tissue forceps was used to remove the body parts, then the doctor had to re-scrape the uterus several times to be sure all of the baby and placenta were removed. Again the tissue forceps were used to remove the body parts and placenta.

The cannula was designed to remove the baby more quickly because of the suction. The top part of the opening of the cannula is designed to start tearing the baby off the wall of the uterus piece by piece, and remove the placenta. The suction simply pulls it all out with very little effort on the part of the doctor.

The suction machine and cannula make it possible to complete an abortion in five minutes or less, thus the physician can easily do ten or more abortions per hour if he does not have to talk to each patient. Unless something was unusual about the pregnancy, our doctors saw the patient for the first time in the procedure room. Each doctor said hello in a different way, but mostly using terms of endearment such as "Baby", "Hon", "Dear". The counselor's job was to tell her what was about to happen to keep her quiet.

Operative procedures notes are made in the charts when the doctor has time between cases, or when the recovery nurse is ready to dismiss the patient.

Using the above techniques, a physician can accomplish ten to twelve first trimester abortions per hour and make approximately 1/3 to 1/2 the total fee, depending upon his negotiated arrangement with the clinic. If a physician does ten abortions per hour and the minimum fee is $75 per abortion, the physician makes $750 per hour.

Our physicians were paid in cash. We did not want any part of the responsibility of his malpractice insurance, so we wanted to be completely independent of the doctors. The doctor's fee was

collected separate from the clinic fee, and since the doctor was not an employee of the clinic, and the clinic did not show that we collected his fee, the doctors were paid in cash, no records were kept for the Internal Revenue Service. Reporting of that income was left entirely to the discretion of each doctor.

Physicians have no overhead in the abortion clinic (if they are not owners) and do not have to wait for the insurance to pay. Abortion charges are paid for before the procedure even if the woman files an insurance claim.

The recovery room nurse monitors patients for at least 1/2 hour and does birth control counseling designed to help the woman choose a method of contraception. The woman is dismissed upon the discretion of the recovery room nurse unless something unusual demands the physician's attention.

The public perception is that abortion falls into the medical category, but that is simply not true. Abortion falls into the abortion category where there are no laws, no rules, making abortion the largest unregulated industry in our nation.

In July, 1983, Channel 4, the CBS affiliate in the Dallas area ran a five day expose on abortion clinics doing abortions on women who were not pregnant. One of our clinics was caught red-handed trying to do abortions on non-pregnant women and allowing an unlicensed doctor to practice medicine.

Channel 4 sent women dressed in jeans, wired for sound, into our clinic to see if we would try to do an abortion on a non-pregnant woman, and we tried.

The expose clearly showed me walking in and out of the clinic with sketches of how we sold abortions to non-pregnant women with the tape playing in the background. "Yes, Babe, you're pregnant. Got your money? Do you want to do it today?"

Even as I held those babies' broken body parts in my hand, I always told myself, "We are helping women have safe, legal abortions." Slowly, painfully, I had to admit we were killing and maiming women, as well as killing a baby in each abortion -- not helping women.

Based on my personal experience in the abortion industry, I am of the opinion that laws controlling the abortion industry are essential to the protection of women and children of the nation. Due to the emphasis on profit prevalent in the abortion industry, the industry will make no effort to clean itself up unless and until it is forced to. It must be remembered that abortion is not a choice women make. Abortion is a skillfully marketed product sold to a woman at a crisis time in her life. She buys the product; and when she realizes it is defective, it is too late to return it for a refund -- the baby is dead.

I admonish you, the elected officials to protect the women of this nation by regulating the abortion industry.

Carol Everett

Sworn to and subscribed before me this 14 day of March, 1990.

Notary Public

DENNIS FRIDGE
COMMISSION EXPIRES
MAY 9, 1990

EXHIBIT A

PEEL DOWN TO OPEN

Rocket USA

RIGID PLASTIC CURETTE

7 MM CVD

CAT.NO.R58.112

LOTNO.85218

CONTENTS
1 Each

INSTRUCTIONS FOR USE
Insert into aspirator handle

CONTRAINDICATIONS
See insert

STERILE

CAUTION
Federal (USA) law restricts this device to sale by or on the order of a physician

FDA Compliance
Policy Guide 7124.33
Dated November 11 1977

WRITTEN TESTIMONY SUBMITTED TO THE

U.S. SENATE COMMITTEE

ON

LABOR AND HUMAN RESOURCES

May 23, 1990

The attached text is an excerpt from a brief submitted to the U.S. Supreme Court by the Family Research Council in support of appellants in Webster v. Reproductive Health Services, 109 S.Ct. 3040 (1989).

The brief gave details of scientific studies that confirm the reality of PAS (post-abortion syndrome), a complex of negative psychological effects suffered by women after an abortion.

The brief also discussed findings that show the negative impact of abortion on the family lives of women who undergo it.

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ADVERSE PSYCHOLOGICAL EFFECTS OF INDUCED ABORTION

A significant number of women who have abortions experience one or more negative psychiatric sequelae. See A. SPECKHARD, PSYCHO-SOCIAL ASPECTS OF STRESS FOLLOWING ABORTION (1987) (hereinafter cited as SPECKHARD).

a. Mental Illness Symptoms Following Abortion. In psychological studies, the mental illness symptomology following abortion are quite varied. They range from adjustment reactions to grief reactions to anniversary reactions to symptoms of guilt, anxiety, depression and psychoses. Approximately 20 percent of post-abortion patients in a 1972 study expressed immediate negative reactions which included guilt, depression, grief, anxiety, sadness, shame, helplessness, hopelessness, sorrow, lower self-esteem, distrust and hostility toward self and others. Osofsky and Osofsky, "The Psychological Reaction of Patients to Legalized Abortion," 42 AM. J. OF ORTHOPSYCHIATRY 48 (1972) (hereinafter cited as Osofsky) (73 of 742 studied expressed guilt feelings); see also I. Kent, Emotional Sequelae of Therapeutic Abortion, presented at 27th Annual Meeting of the Canadian Psychiatric Association, Saskatoon (September 1977) (hereinafter cited as Kent) (43 percent expressed anxiety); and P. Ney, Mental Health and Abortion (1988) (unpublished manuscript) (hereinafter cited as Ney 1988).

Guilt is a frequently documented emotional reaction to abortion. A review of the abortion literature found severe guilt occurring in up to 23 percent of the post abortion patients. E. Moore-Caver, "The International Inventory on Information on Induced Abortion," International Institute for the Study of Human Reproduction (1974). "Clinicians have documented many cases of women who function well before their abortion, but subsequent to their abortion they experience severe psychological problems precipitated by guilt over the abortion." SPECKHARD at 5.

In a recent in-depth case identification study, "the emotional responses to abortion as a 'stressor event' were most dramatic, with grief, guilt, anger, fear and depression being most predominant, with a large portion (over 85 percent) of the sample reporting experience with all five of these emotions." SPEAKHARD at 67. Dr. Speckhard, as well as many other researchers, found that the most serious psychological complications sometimes were delayed as much as 20 years post- abortion. Id. at 101-103; see also Kumar and Robson, "Previous Induced Abortion and Ante-Natal Depression in Primiparae: Preliminary Report of a Survey of Mental Health in Pregnancy," PSYCHOLOGICAL MEDICINE 711 (1978); Mester, "Induced Abortion in Psychological Outcome of Induced Abortion," 87 BR.J. OF OBSTET. & GYN. 1115 (1980); and Hittner, "Feelings of Well-Being Before and After Abortion,: 9 AM. MENTAL HEALTH COUNSELORS ASSOC. J. 98 (1987). "[P]re-occupation with the characteristics of the aborted child (experienced by 89 percent of

the subjects), along with nightmares, flashbacks, hallucinations and perceived visitations related to the abortion, were viewed in this research as indicators that subjects had a high degree of psychological presence regarding the aborted fetus." SPECKHARD at 101. "Although this grief process was often found to be delayed, all of the subjects reported having one or more symptoms of grief which occurred either immediately or in the long term." Id.

b. Delayed Psychological Consequences of Abortion. While a number of studies show immediate adjustment or mental illness reactions to induced abortions, most of the more serious effects were the long-term and delayed psychiatric symptoms. A study conducted four weeks after the termination found that abortion patients had much poorer psychological adjustments than maternity patients. D. GOLD, THE ABORTION CHOICE: PSYCHOLOGICAL DETERMINANTS AND CONSEQUENCES (1984). See Ewing and Rouse, "Therapeutic Abortions and a Prior Psychiatric History," 130 AM. J. OF PSYCHIATRY 37 (1973); Handy, "Psychological and Social Aspects of Induced Abortion," 22 BR. J OF CLINICAL PSYCHOLOGY 29 (1982). In one study 12 to 18 months after initial presentation, a significantly greater proportion of the women who had abortions were under psychiatric treatment, admitted to a greater increase; in use of alcohol and tobacco, used more tranquilizers and experienced more adverse personality changes than those whose pregnancies were not terminated. Ney 1988 at 3.

Some of the long-term and delayed negative psychological effects for women who had abortion can also include severe grief, isolation from social settings, suicide attempts, abdominal pains and severe depression, especially on the abortion or birth anniversary dates. See "Greenglass, Therapeutic Abortion and Psychiatric Disturbance in Canadian Women," 21 CANADIAN PSYCHIATRIC ASSOC. J. 45 (1976); Tischler, "Adolescent Suicide Attempts Following Elective Abortion: A Special Case of Anniversary Reaction," 68 PEDIATRICS 670 (1981); T. WALL, PSYCHOLOGICAL AFTER-EFFECTS OF ABORTION (1986) (unpublished master's thesis, Wayne State University); Spaulding and Cavenar, "Psychoses Following Therapeutic Abortion," 135 AM. J. OF PSYCHIATRY 364 (1978); and Gould, "Post-Abortion Depressive Reactions in College Women", 28 J. OF AM. COLLEGE HEALTH ASSOC. 316 (1980).

Reports of long-term guilt and grief, similar to the one quoted here, have been frequently received by Amici.

> "Little did I know at 19 years old that my abortion was the beginning of years of pain, heartache, guilt, such trauma that led me to drinking and drug abuse to numb the pain, that I couldn't change what I did ... The grieving process is undescribable. The mourning for a child you killed out of immaturity, fear, no where to turn. To block some thing like this out, you can't" L-1.4.

As repeat aborters show higher levels of medical sequelae, repeat aborters demonstrated significantly higher emotional distress scores in interpersonal relationships than other women. A study of 71 women with multiple abortions showed that they had more often considered suicide and scored higher on borderline personality pathology and depression than the comparison sample. K. Franco, Dysphoric Reactions in Women After Abortion (1984) (unpublished paper, Medical College of Ohio). Forty percent of the women reported anniversary reactions and half of the women aborting sought psychotherapy months or even years after the procedure. Id.

Although some psychotherapists may be minimizing the impact of abortion's stress, Mester, "Induced Abortion in Psychotherapy," 30 PSYCHOTHERAPY AND PSYCHOSOMATICS 98 (1978), many describe findings of women who did not enter psychotherapy on account of any perceived emotional after-effects of abortion but who were suffering from post-abortion trauma. See Kent at 2. Once alerted to the abortion history, psychotherapists found that a high percentage of these patients had many emotional symptoms due to an induced abortion. Id.

c. Post-Abortion Stress Including Post-Abortion Syndrome. Some clinicians are now using the term Post-Abortion Syndrome (PAS) to describe a family of psychiatric symptoms related to abortion. PAS is being discovered in a significant percentage of women who have had abortions, especially multiple abortions. The symptoms of PAS fall primarily into three main categories of response: (1) re-experience of the abortion trauma, (2) avoidance behaviors, (3) associated symptoms not present prior to abortion. A. SPECKHARD, POST-ABORTION COUNSELING 3-4 (1987). Clinicians, counseling those with past abortions, often equate PAS with a type of the well-recognized post-traumatic stress disorder (PTSD). Id. "Like the Vietnam veterans who returned from their military experiences severely scarred psychologically, post-abortive women have experienced an event that they perceive to be both traumatic and outside the realm of general experience." Id. at 4.

A central component of long-term development of PAS is a woman's reliances upon the emotional defenses of denial and repression, alongside the use of avoidance behaviors to cope with the post-abortion stress. A. SPECKHARD, POST-ABORTION COUNSELING at 2, 9-10. In time, the symptoms cannot be repressed, denied or avoided and PAS will become apparent. Id. at 11. Many women who experience PAS present themselves for therapy on the anniversary due date of the aborted child. Id. Of 230 women studied, 80 percent suffered chronic negative psychological sequelae which clearly could be classified as severe post-abortion stress. D. REARDON, WOMEN EXPLOITED: A NATION DECEIVED (1986) (hereinafter cited as REARDON). Post-abortion stress (PAS), if not adequately treated, may evolve into a disabling mental illness of chronic and

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long-term duration. A. SPECKHARD, POST-ABORTION COUNSELING at 11. Recently Amici received the following letter:

> "About Post-Abortive Stress. It is real. Like a person who goes to war and comes home only to have people tell him, 'Oh. That's behind you. You have to go on and forget about it.' A woman who undergoes an abortion can no more follow that kind of shallow advice than a veteran suffering from post-war stress. "You don't just 'put' the taking of a human life from inside your womb, 'behind you.' It never leaves your memory. No matter how hard you try you don't forget. No one told me that I would experience the guilt and sadness that I do now, at the time of my abortion. I get depressed more than I ever have before, especially when the anniversary of my pregnancy, abortion and the time when my child would have been born, comes around. I always think about my baby. Even if the Lord grants me another child, it will never replace the child I carried for 11 weeks or more." L-1.5.

A psychiatrist and abortion doctor who has performed over 20,000 abortions describes the psychological effects of induced abortion as follows:

> " 'There is no question...about the emotional grief and mourning following an abortion. It shows up in various forms. I've had patients who had abortions a year or two ago--women who did the best thing at the time for themselves--but it still bothers them. Many burst out crying ... There is no question in my mind that we are disturbing a life process .... A psychological price is paid .... Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy.. I know that as a psychiatrist.'" The Washington Post, Feb. 14, 1989 at F2.

Both physical complications like PID, miscarriage and sterility, and psychological effects such as PAS, guilt, depression and suicidal tendencies, have one overriding similarity: unless treated effectively, they will have profound and lasting adverse effects on the women and quite probably her family.

ADVERSE EFFECTS OF ABORTION ON THE FAMILY

Large-scale negative psychosocial effects of abortion often become more visible when attention shifts form the pregnant women herself to relationships with others, especially those family relationships, which comprise the basic unit of American Society. S.Rep. No. 98-149, 9th Cong., 1st Sess. 44 (1983). Abortion and a stable marriage seem particularly incompatible: marriage status makes the abortion decision even more difficult and according to the research, abortion seems to signal the beginning of the end for many conjugal relationships.

a. Abortion's effects on spousal relationship. In a 1979 study, nearly half of the 150 women who elected abortion ended their relationships with the putative father. S. Plattner, "Conceptual systems and sex role attitudes and beliefs and their effect on short-term abortion outcome," (1979) (unpublished doctoral dissertation, University of Colorado). Interviews with over 400 men at an eastern abortion clinic also revealed that most of their relationships (70 percent) with the aborting women failed within one month after the abortion. E. Milling, "The Men Who Wait," WOMEN'S LIFE, April 1975 at 48-71. Many researchers identified serious sexual problems experienced by women who had abortions. See Gerrald, "Sex Guilt in Abortion Patients." 45 J. OF CONSULTING AND CLINICAL PSYCHOLOGY 708 (1977). In a recent study, "many (69 percent) of the subjects reported becoming sexually inhibited, and having feelings of sexual anxiety (35 percent) following their abortions." SPECKHARD 103.

Two women's personal stories bring these findings into focus:

> "At the time of my pregnancy I thought that the council I received was easiest to believe--which was 'that the contents of my uterus was only tissue and that aborting the product of our conception was the best choice for my life.' ... The death of my child created intense relational problems with the baby's father and within one year our relationship ended. The end to our love did not end the pain, the nightmares, the emotional tie with the baby's father, the extremes of drug and alcohol use, the guilt and regret and the confused running from the tragic murder." L-1.6.

> "Jeff reacted to it by trying to commit suicide. Later, when I become pregnant again, he didn't want to feel the baby kick or anything. He said that it reminded him too much of the baby that was aborted and five days after I gave birth to our son, Jeff left and I divorced him. He has only seen Jason once since he was born." L-1.7.

Many of the married couples in a recent clinical report showed that many years after the abortion they were still troubled by a past abortion of the intensity of their feelings and personal meaning of this death experience. Mattinson, "The effects of Abortion on a Marriage. Abortion: Medical Progress and Social Implications," 115 CIBA FOUN. SYMP. 165 (1985). "Sometimes, apparently having been unable to mourn the loss of a child at the time of the abortion, the spouses show a delayed grief reaction, maybe mild, but persistent, or may occur in more extreme form only many years later when a subsequent loss of a different nature triggers off repressed or conflicting feelings related to the

earlier loss of the baby." Id. at 165. "Because of the basic inequality between partners in the abortion decision, the capacity to develop trust, enhance communication and problem solving skills, and to build intimacy, honesty and companionship is severely handicapped and restricted." V. Rue, "Abortion in Relationship Context: How Abortion Affects Males," ASSOC. FOR INTERDISCIPLINARY RESEARCH NEWSLETTER, Summer 1988 at 3 (hereinafter cited as Rue 1988).

b. Abortion's effects on "surviving children". Approximately 50 percent of children in North America are or soon will be abortion survivors, i.e., children who have had siblings terminated by induced abortion. Ney, "A Consideration of Abortion Survivors." 13 CHILD PSYCHIATRY AND HUMAN DEVELOPMENT" 168, 169 (1983) (hereinafter cited as Ney 1983). "If abortion is selected as a solution to the immediate problem of unwanted pregnancy, older children in the family may misinterpret the act as a great threat and my require psychiatric treatment." McCoy, "Emotional Reaction of Women to Sterilization and Therapeutic Abortion." 75 J. OF OBSTET. 7 GYN. OF THE BRITISH COMMONWEALTH 1054 (1968). Children are becoming increasingly aware when potential siblings are aborted that they are the survivors. Ney, 1988 at 15. "[K]nowing that the child is chosen to live makes life difficult for a child. He may feel tightly bound by obligations to the one who saved him from termination. Knowing that he was allowed to exist because he was desired may make him try too hard to stay desirable. If he becomes aware of the fact that siblings were terminated, and he is the survivor, he also may feel guilty for existence." Id. at 16. See Crell and Rabon, "The Effects of Sibling Death on Surviving Child, A Family Perspective," 18 FAMILY PROCESS 471 (1979); V. Rue, "The Impact of Induced Abortion on Surviving Siblings: Case Studies," Association for Interdisciplinary Research Newsletter, Fall 1988 at 2-6. Evidence indicates that post-abortion depression also hinders mother-infant bonding in a subsequent pregnancy and can lead to child abuse. Ney, "Relationship Between Abortion and Child Abuse," 24 CAN. J. OF PSYCHIATRY 61 (1979). A 1979 report outlined eight methods of how an increasing rate of therapeutic abortion is leading to an increasing rate of child abuse. Ney, "Relationship Between Abortion and Child Abuse," 24 CAN. J. OF PSYCHIATRY 610 (1979), 610-612. Ney's reports also underscore the fact that no evidence indicates elective abortions will reduce prevalence of child abuse, contrary to popular assertion that elective abortion decreases child abuse my making sure children are wanted. Id., at 617. The guilt and depression following an induced abortion has been identified in many case studies as a factor in neglect and abuse of the subsequent child. Ney 1988 at 15.

For children who have siblings terminated by abortion, the children may have similar psychological conflicts to those children who survived disasters or illness which kill another sibling, such as unresolved guilt, fear of parents, obsession to please parents, blatant hostility. Ney, 1983 at 58.

c. Abortion's effects on the family unit. For women, abortion sometimes provides immediate relief, but generally guilt, secrecy, depression, denial and delayed psychological stress follow. For men, it increases masculine insecurity and promotes guilt, alienation, role conflict and lack of communication. See Rue, 1988 at 3. For children, abortions have been known to produce intrapsychic conflict, insecurity and mother-child bonding problems. See Cavenar, Maltbie and Sullivan, "Psychiatric Sequelae of Therapeutic Abortions," 39 N.C. MED. J. 101 (1978); Ney, 1983 at 168; and REARDON, 1986 at 2. One particular result rises clearly from the studies and letters--relationships end after abortions. While other predisposing factors certainly affect some of these familial problems subsequent to abortions, abortions do not assist in strengthening the bonds of marriage and family. Indeed, it is a stressful precipitant and often leads to the unraveling of these important support systems.

While the claim that abortions are safer than childbirth is questionable at best when the focus is only on mortality rates (see Amici Curiae Brief of Feminists for Life, Women Exploited by Abortion et al.), it is particularly erroneous in light of the road, adverse medical complications, psychological effects and impact on the family that result from induced abortions. Conservatively, 22.5 million abortions have occurred since 1973. If only 10 percent of the women experience any one of these adverse effects, 2.25 million women would be affected. Abortions harm women and families.

Any analytical framework, such as Roe's trimester scheme, which seeks to balance the women's rights and the state's interests, must be capable of considering all health interests of the mother, including psychological, physical and psychosocial effects, as well as the important and legitimate state interests of protecting "familial integrity and health of the mother" in the abortion context, see e.g., H.L. v. Matheson, 450 U.S. 398, 411 (1981), Roe, 410 U.S. at 162, as well as of the "potential human life." Id. at 159-160. Roe and its progeny unfortunately ignore the serious but non-mortality impact of abortion on women. With 15 years of developing scientific evidence about the effects of abortion, the Court must, at this critical juncture, examine evidence of morbidity in its reconsideration of Roe's trimester approach and its determination of who should draw the line to protect the health of the women along with the family--the state legislature or the courts.

PREPARED STATEMENT OF MARY CUNNINGHAM AGEE, EXECUTIVE DIRECTOR, NURTURING NETWORK

Senator Metzenbaum, Senator Hatch, Senator Kennedy, Senator Coats and other members of the Senate Labor and Human Resources Committee:

Thank you for inviting me to present testimony regarding the work and findings of the Nurturing Network. I refer to a unique support network which enables women who have made the conscious choice to bear the fruit of what may well be an unexpected, even unwanted pregnancy; and with professional guidance leavened with love to give their children the opportunity to grow and mature in the best possible environment.

That life may be nurtured by the natural mother herself -- hopefully with the father's support, our Network provides counsel and the practical assistance she may need to prepare for the challenges of raising a child. For those women who feel that their financial, emotional or social circumstances would make parenting untenable, we offer the guidance to establish a thoughtful and informed adoption plan.

Let me briefly describe the Nurturing Network and describe how it came into being five years ago. We began by asking, "How many of last year's 1.5 million abortions, and God knows how many more in the shadows, were truly the result of the exercise of 'free choice'?" As a result of a survey we conducted, over one hundred women who had either experienced a crisis pregnancy in their past, or who were actually in the midst of this challenge,

chose to respond to this inquiry. We learned that in over 90% of these cases -- those who had "chosen" abortion would have -- and I quote -- "preferred to find a positive alternative" -- if only it had been made available.

Granted these results were gleaned from a small scale, qualitative study and it was undertaken on a somewhat informal basis at that. But the fact is there exists very little hard data about the motivations and concerns of women facing crisis pregnancies. And so, we must turn to research like ours to perhaps hear a message that otherwise may not be available. The ambivalence, and in some cases, outright regret expressed toward the abortion alternative by so many women in our sample suggests a fundamental need. A need for more than one option. A need for "choice" to really mean something. Quite simply, these women defined the need for a positive alternative to abortion.

If the limited scope and informality of our research left me still unconvinced, the outpouring of response to the existence of our program over the past five years has removed any question about the message these women were sending. Last month, the number of women we have served reached 1,000 and our volunteer membership now surpasses 4,500. We are headquartered in Boise, Idaho, where we have 75 volunteers in our head office ready to help. We have just received a phone number for women to call free of charge -- 1-800-TNN-4MOM.

In order to better meet the needs of our clients, we have tried to learn more about both the scope of this problem and who is most likely to encounter it. We learned from the the Centers for Disease Control that over 70 percent of all abortions in 1983 (the last year that formal surveillance was conducted nationwide), were performed for women age 20 or older. To put this in perspective, we are talking about at least 1,120,000 women in that year alone. The CDC also reported that the single largest age category was women over the age of twenty-five.

In order to verify if this pattern still held true, we contacted a broad sample of crisis pregnancy centers and abortion clinics across the country. They reported with noteworthy consistency a similar profile of the woman most apt to seek their services. Contrary to the widespread stereotype of an impoverished, uneducated teen, we were repeatedly told that the most likely candidate for an abortion last year was 20-24 years of age, white, middle-class and she had earned at least a high-school degree.

These facts are not shared to in any way try to diminish the severity of the teenage pregnancy problem. They are offered to focus your attention, as mine has been, to a large group of women who until now have been largely overlooked. There is, after all, an unspoken assumption that the college-educated or career-oriented middle-class woman knows how to avoid an unwanted

pregnancy, that she is rarely, if ever, faced with one and if so, can take care of herself.

Our research reveals just the opposite. This is the woman who, without support, often feels she has "too much to lose" by continuing an unwanted pregnancy. She is the one whose college peers are most apt to say, "You should have been smarter than that. This isn't supposed to happen to someone like you." She is the one whose boss is still apt to find a good excuse for terminating her employment and whose family is still apt to respond with shame and rejection.

This woman is your neighbor, your staff member, and maybe even your daughter. These are women you see every day. I have found too often that when a societal issue becomes as controversial as this one, we lose touch with the faces behind the numbers. The rhetoric overcomes basic human compassion and drains energy from desperately needed practical assistance.

Our research has shown that there are basically three explanations these women give as to why they became pregnant.

First, the woman was living with or had a long-term relationship with the father of the baby who abandoned her when she got pregnant. These women had no reason to believe that these men would not marry them or help shoulder the responsibilty of a baby.

Second, the unplanned pregnancy was a result of a failed birth control device. To put it bluntly, these women learned first hand the painful reality that every birth control device has a failure rate except abstinence. Having a Ph.D. does not guarantee that these devices will be 100 percent effective. Again, these women represent our daughters, our friends, and those with whom we are closely associated.

Third, the pregnancy is a result of a "lapse of judgment." The woman makes a one-time bad decision and is faced with a regrettable consequence.

So, **why** do these women have abortions? Our research shows that there are **four sources of pressure** directed to a woman facing this most personal and vital decision. These decisions have little to do with "freedom of choice"... and a lot more to do with unfair trade-offs imposed from the outside. The vast majority of women who submit themselves and their babies to abortion (our research shows 91 percent) do so, not out of **"freedom of choice"** but because they feel they have **no other choice.**

My years of experience with over 1,000 women facing this crisis has shown me the following four influences weigh heavily in the abortion decision:

1) The **father of the baby.** More often than not, the frightened father of the baby will issue an ultimatum: "Either me or the baby."

2) The **family.** The embarrassed family with concern for the social stigma this can represent will issue a different ultimatum: "Either your family or the baby."

3) The woman's **peers.** Misguided friends often judge a single, pregnant woman and tell her "she should have been smarter than to let herself get pregnant." Their subtle ultimatum: "Either your friends or the baby."

4) Finally, the **employers.** It is enlightening -- if not disheartening -- to note that discrimination still takes place in the workplace towards a woman who is pregnant. They are told that this "will not enhance their credibility" and are frequently removed from better jobs. This discrimination is also still found at educational institutions where students may be asked to leave for fear they might represent a "bad example" to alumni and other students. Their ultimatum: "Either your career and education or the baby."

None of these ultimatums have anything to do with "freedom of choice." All have to do with impossible tradeoffs.
Many women report that more than one of these pressure groups forced her to an abortion decision.

This means to me that we need a lot less rhetoric and less judging. We need a lot more practical compassion.

This is why the Nurturing Network was created -- to give these women a real alternative -- one which recognizes their unique values, needs and circumstances. Our purpose is not to remove an option -- but to create one. It is not even to spend time debating the merits of one alternative over another -- but to make sure that no woman feels she has no other choice.

The tragic irony of our Network's efforts is that we are already starting to find a higher incidence of the adoption choice among the clients we serve than is often reported by programs addressing primarily the teen population. It is perhaps precisely because of our client's promising futures that they may be more willing to consider the adoption alternative. After all, the cause of their crisis pregnancy is more likely to be rooted in a failed relationship or birth control device than in weak self-esteem. And so, their assessment of what would be best for their child's upbringing is sometimes more pragmatic.

At a time when last year alone we learned of two million couples who were unable to adopt, it seems regrettable, to say the least, that we persist in failing these mothers, both biological and adoptive. Our clients have shown us time and time again that an unwanted pregnancy does not have to mean an unwanted baby.

I believe there is a profound correlation between how much support we are willing to give women with crisis pregnancies and how many healthy infants will be available for the thousands of potential parents wishing to adopt. Unless we are willing to offer the emotional, social and financial support needed by women facing this kind of pregnancy, we cannot legitimately express either condemnation or surprise when we discover that they have chosen a less hopeful solution.

And, here is how we operate. We assist in every facet of a pregnant woman's needs, from initial pregnancy testing to delivery of her baby and provision of information on parenting and adoption.

We specifically offer the following:

Nurturing Homes in all fifty states where a client is given more than just another place to stay. Each nurturing family has been carefully selected through a detailed questionnaire and interviewing process. All nurturing families understand the challenges our clients face and are committed to providing the nurturing that is needed at this sensitive time.

Medical Assistance, wherein each client is offered competent medical care to protect her health and that of her unborn child. Among the members of our network are literally hundreds of dedicated doctors and nurses throughout the country. Each is

prepared to assist -- often at a reduced rate -- in planning a balanced program of nutrition, exercise and good health.

Counseling through which licensed nurses, social workers, and other counselors with special training are able to promote healing and self-esteem. Each counselor is prepared to provide valuable information on the resources available through our network based upon a detailed evaluation of each mother's needs.

Financial Assistance, wherein each client is offered a coordinated plan for handling the many expenses associated with her pregnancy. We are able to accomplish this through privately donated funds, public assistance, employment opportunities and loan programs.

And, bearing in mind our primary focus on college and working women, we also offer:

Educational Programs, because there is no need for a healthy pregnancy to limit a woman's educational opportunities. If a client wishes to protect the confidentiality of her pregnancy or is receiving undo pressure at her current institution, we can arrange for a temporary transfer to a college of comparable academic standing through our extensive network of participating schools and universities.

Career Programs that enable each client to preserve her own future and that of her unborn child. Through an innovative program of mentorships at participating companies throughout the United States, a working woman can take a temporary leave of absence and work for an employer who respects her accomplishments and supports her decision at this vulnerable time. If a woman chooses to relocate, our network is also able to offer a nurturing home, medical care, counseling and any other supportive services she may need in that area.

I am sharing our action program with you today on behalf of my colleagues at the network in the hope that you will find further clues to help you translate your commendable concerns into similarly practical, constructive action. It costs as little as $65.00 to abort a life -- and as much as $6500.00 to bring it into this world. We think the difference is worth it.

Let us continue to work together for the sake of our generation -- and the next.

April 17, 1990

Christian
Church
(Disciples of Christ)

In The United States And Canada

OFFICE OF
GENERAL MINISTER
AND PRESIDENT

222 S. DOWNEY
P.O. BOX 1986
INDIANAPOLIS,
INDIANA 46206
(317) 353-1491

John O. Humbert
General Minister and President

K. David Cole
Moderator
Kansas City, Missouri

Fran Craddock
First Vice Moderator
Indianapolis, Indiana

C. William Bailey
Second Vice Moderator
Seattle, Washington

The Honorable Edward M. Kennedy
United States Senate
Washington, DC 20510

Dear Senator Kennedy:

I am writing to request that the attached testimony be included in the record of hearings on S. 1912, The Freedom of Choice Act of 1989. The Christian Church (Disciples of Christ) in the USA and Canada is a protestant denomination with 1,100,000 members, predominantly in the United States. Our General Assembly is our major plenary body which meets every two years with 7-8,000 registrants attending. Our Assembly is on record from 1975 as supporting the decision on abortion being made not by the legislators, but by the individuals involved in the pregnancy; not on grounds of facing the decision on the basis of possible criminal charges, but on the basis of ethical and moral grounds.

Thank you for your attention to this matter.

Sincerely,

John O. Humbert

John O. Humbert
General Minister & President

JOH-m

encl.

Testimony from
John O. Humbert
General Minister and President, Christian Church
(Disciples of Christ) in the USA and Canada

The General Assembly of the Christian Church (Disciples of Christ) meeting in Indianapolis, IN, in August-1989, adopted Resolution 8954, Emergency Resolution Concerning Webster v. Reproductive Health Services (copy attached). That resolution declared the General Assembly "reaffirms our historic commitment to reproductive freedom for women."

What is that "historic" commitment? It is the action of the San Antonio Assembly in 1975, Resolution #7524:

> "Whereas legislation is being introduced into the U.S. Congress which would embody in law one particular opinion concerning the morality of abortion which would limit each individual's freedom and responsibility in such matters.
>
> Therefore be it resolved that the General Assembly:
>
> 1) Affirms the principle of individual liberty, freedom of individual conscience, and sacredness of life for all persons,
>
> 2) Respects differences in religious beliefs concerning abortion and opposes...any attempts to legislate a specific religious opinion or belief concerning abortion upon all Americans,
>
> 3) Provides through ministry of the local congregation,pastoral concern, and nurture of persons faced with the responsibility and trauma surrounding undesired pregnancy."

Furthermore, as the General Assembly of this church met again in San Antonio in 1983, in Resolution #8345 the General Assembly resolved to:

> "encourage counselors, health personnel and counselees to give consideration to all possible creative alternatives to unwanted pregnancies."

This is the "historic" position of the General Assembly regarding abortion, with regard to counseling and the abridgement by law of individual responsibility and choice. It is a position which strongly supports the place of decision making on abortion being not with public legislators, but with the individuals involved with the pregnancy; not on grounds of facing the decision on the basis of possible criminal charges, but on the basis of ethical and moral grounds.

No. 8954

EMERGENCY RESOLUTION CONCERNING WEBSTER V REPRODUCTIVE HEALTH SERVICES

WHEREAS, the Supreme Court on July 3, 1989, in a 5 to 4 ruling on Webster v Reproductive Health Services, upheld the Missouri law which restricts women's access to publicly funded abortions, bans state employees from counseling women about the option of abortion, requires expensive and questionable fetal viability tests after the 20th week of pregnancy, and prohibits any state-funded medical facility from performing abortions; and

WHEREAS, the majority of United States citizens are opposed to making abortion illegal, (NEWSWEEK, 7/17/89, Page 15); and

WHEREAS, legislation such as the Missouri law discriminates against poor women who do not have the resources to pay for expensive tests, private abortions, or travel to another state, and therefore threatens the lives of poor women; and

WHEREAS, the Supreme Court has agreed to hear cases in its fall term that would require parental notification for minors seeking abortions and such notification is most likely to greatly aggravate the negative circumstances of those young women who have difficult or unsupportive relationships with their parents or who already are abused or even molested by their fathers or other family members; and

WHEREAS, making abortion illegal, when many committed Christians do not even agree when life begins, would become coercion and create widespread disrespect and cynicism for what may be an unenforceable law; and

WHEREAS, law has consistently upheld that no person may be required by law to risk one's body for the well-being of another (e.g., no one is required by law to donate a kidney to save the life of another); and

WHEREAS, the General Assembly of the Christian Church (Disciples of Christ) in its 1975 meeting in San Antonio, Texas affirmed, in Resolution 7524, our "respect for differences in the religious beliefs concerning abortion and oppose, in accord with the principle of religious liberty, any attempt to legislate a specific religious opinion or belief concerning abortion upon all Americans";

THEREFORE, BE IT RESOLVED that the General Assembly of the Christian Church (Disciples of Christ) meeting in Indianapolis, Indiana, July 28-August 2, 1989, reaffirms our historic commitment to reproductive freedom for women; and

BE IT FURTHER RESOLVED that this Assembly expresses opposition to the recent Supreme Court decision of Webster v Reproductive Health Services and opposition to any laws that restrict women's guaranteed access to abortions under Roe v Wade and to any legal restrictions that unfairly penalize poor and young women seeking abortions; and

BE IT FURTHER RESOLVED that the General Assembly encourages those members of the Christian Church (Disciples of Christ) who support a woman's right to reproductive freedom oppose state or federal legislation which would explicitly or effectively limit the access of any woman to legal and safe abortion counseling and services, and notify their state and national legislators of their views and the action of this Assembly; and

BE IT FURTHER RESOLVED that the General Assembly encourages those members of the Christian Church (Disciples of Christ) who support a woman's right to reproductive freedom and who are living in states where public health money is not available for legal abortion services, consider financial support of private agencies offering these services to women, regardless of their ability to pay; and

BE IT FURTHER RESOLVED that this Assembly asks the General Minister and President to notify the Governors, State Attorneys General, the President of the United States, members of the U.S. Congress, and the Supreme Court about the action taken by this Assembly, including a copy of this resolution.

STATEMENT OF

UNITED CHURCH OF CHRIST
COORDINATING CENTER FOR WOMEN IN CHURCH AND SOCIETY

SUBMITTED TO THE

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

ON THE

FREEDOM OF CHOICE ACT OF 1989
S. 1912

The Coordinating Center for Women in Church and Society of the United Church of Christ is committed to maintaining freedom of choice for women in the matter of abortion as guaranteed by the Constitution in Roe v. Wade. As an established agency of the General Synod of the United Church of Christ, the Coordinating Center for Women fully sup;ports the action of General Synod Eight (1971), which affirmed the intent of Roe v. Wade, and of General Synods Nine (1973), Eleven (1977), Twelve (1979), Thirteen (1981), Sixteen (1987) and Seventeen (1989), each of which reaffirmed the action of Roe v. Wade in providing freedom of choice, and access to safe legal abortions for women in problem pregnancies.

In light of the Webster decision of 1989, this right of choice is seriously threatened. Therefore, the United Church of Christ Coordinating Center for Women in Church and Society supports the passage of the Freedom of Choice Act of 1989. S. 1912 with the intent that it codify the framework of the Roe decision in Federal law and keep abortion a safe and legal choicer for women in every state.

The Coordinating Center for Women in Church and Society is an instrumentality of the United Church of Christ mandated to address the concerns of women and eliminate sexism in church and society. The United Church of Christ is a 1.6 million member denomination created by the 1957 merger of the Congregational Christian and Evangelical and Reformed churches.

JOSEPH R. BIDEN, JR., DELAWARE, CHAIRMAN

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TERRY L. WOOTEN, MINORITY CHIEF COUNSEL AND STAFF DIRECTOR

United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 5, 1990

Dr. Jacqueline Darroch Forrest
Vice President for Research
Alan Guttmacher Institute
111 Fifth Street
New York, NY 10003

Dear Dr. Forrest:

Thank you again for testifying at the May 23, 1990 hearing.

I have enclosed additional questions from Senator Hatch. I would appreciate it if you would answer them and return your answers to the following address by June 20, 1990:

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

If you have any questions, please do not hesitate to contact Kelly Signs at (202) 224-5701.

Again, thank you for your testimony.

Sincerely,

Howard M. Metzenbaum
United States Senate

HMM/jo

From Senator Orrin Hatch

Questions for Dr. Forrest

1. Dr. Forrest, I am delighted with your statement that, "At some point, we as a society are going to have to face up to the fact that if we really want to do something to bring down the number of abortions we are experienceing, we are going to have to do something to bring down the number of unintended pregnancies." I would far rather be discussing prevention than abortion in this committee, but it's always the other way around. What can we as a Committee be doing to achieve your objective of bringing down the number of unintended pregnancies in this country?

2. Dr. Forrest, you use a lot of data on abortion statistics? What year was your data collected? Do you have any data about the number of abortions in 1985?

   Follow-up--I am interested in other statistics. Could you tell me or provide for the Record the following information:

   1. How many abortions are done because of rape?
   2. How many abortions are conducted because of genetic abnomalities?
   3. How many abortions are performed to save the life of the mother?
   4. How many abortions are performed after the baby is 22 weeks in utero?
   5. How many abortions are performed because of sex selection?

3. Surgeon General Koop has described the difficulty in documenting the number of abortions because: 1) approximately half of the total abortions are done in free-standing abortion clinics where records are not kept, and 2) 60 percent of the women who have an abortion deny having one when questioned. How many abortions are unreported and not compiled by your data?

4. Are our nation's family planning clinics giving adoption a proper emphasis as an alternative abortion?

5. It simply escapes me why adoption gets such short shrift in this debate. Why can't we do better in this regard?

The
Alan
Guttmacher
Institute

June 20, 1990

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcommittee
Room 224 Dirksen Senate Office Building
Washington, DC 20510

Dear Sen. Metzenbaum,

I am pleased to have the opportunity to provide further information to the Labor and Human Resources Committee in connection with my testimony on May 23 on the Freedom of Choice Act. My responses to the additonal written questions from Senator Orrin Hatch follow.

1. My testimony emphasized prevention of unintended pregnancy because that is something that should have the strong support of all members of Congress, especially those who are antiabortion. The fact that the National Right to Life Committee cannot support prevention continues to puzzle me. I am heartened that you, Senator Hatch, are committed to prevention through family planning as you explained at the March 27 hearing.

This subject is particularly relevant to this committee since the single most important action you can take would be to reauthorize Title X of the Public Health Service Act, over which this committee has jurisdiction. As you know, this legislation has been pending for years. It has been ready for Senate floor action for months. Any encouragement you can suggest to the Senate leadership to commence floor action on this bill, S. 110, and to promote its swift passage would be extremely helpful.

You have received extensive testimony on the effectiveness of Title X in the course of the committee hearing and mark-up sessions. I will only repeat here the common sense conclusion that contraception, when used properly, works to prevent unintended pregnancy. This is buttressed by research which shows that the small proportion of women at risk of unintended pregnancy who were not using any form of contraception -- about one in ten -- were responsible for over half of all unintended pregnancies.

Promoting access to family planning services and information, along with a parallel effort to develop safer, more effective and more acceptable contraceptive methods, can only help in reducing the need for abortion.

2. Data on abortion come from a number of Alan Guttmacher Institute projects. The most recently published information on abortion rates, which was used as a basis for the testimony, covered 1985. These data were collected in 1986 and published in 1987. The information was collected through a survey of all known abortion providers in the United States, with intensive followup to achieve as accurate reporting as possible. Statements regarding the total number of abortions annually are based on these data as well as on preliminary tabulations of data from the survey covering abortions in 1988. These data were collected in 1989-1990 and a report of the survey results has been accepted for publication.

Information on who has abortions comes from a nationally representative survey of 9,480 abortion patients conducted in 1987.

Data on why women have abortions were collected during Nov. 1987 - Mar. 1988, in a survey of 1,900 abortion patients nationwide.

Rape: 1 percent of all women surveyed in 1987-88 said that rape or incest was a reason contributing to their decision to have an abortion.

Genetic abnormalities: 13 percent of women surveyed in 1987-88 said a reason contributing to their decision to have an abortion was possible fetal health problems. Eight percent of these (one percent of all women surveyed) said a physician had advised them that the fetus had a defect or was abnormal. Further information on the extent to which the women's fears of fetal abnormalities had been confirmed was not available.

Abortion to save the woman's life: Seven percent of women surveyed in the 1987-88 AGI study said one of the reasons contributing to their decision to have an abortion was that the woman had a health problem. Most of these women, 79 percent, said this was a serious physical problem (as opposed to mental or emotional problems and physical discomforts or complaints), but we did not obtain information on whether or not the health problem threatened the woman's life. Fifty-three percent of these women said one of their reasons for choosing abortion was that a physician had told them their health problem would be made worse by the pregnancy.

Abortions after 22 weeks in utero: Length of pregnancy is usually expressed in time since the woman's last menstrual period. Implantation, or the establishment of the embryo in the uterus, usually occurs about a week after fertilization or three weeks

after the woman's last menstrual period. Thus, "after 22 weeks in utero" would be equivalent to after 25 weeks since the woman's last mentrual period. Nationally, an estimated 100-200 abortions each year occur after 24 weeks since the last menstrual period. This is equivalent to 0.006-0.012 percent of all abortions. The number occurring after 25 weeks is even less.

Sex selection: No respondent to our survey of 1900 women having abortions said she chose abortion for the purpose of sex selection.

3. The key difficulty in obtaining information about induced abortions in the United States is not documenting the number of abortions that occur, but rather obtaining accurate reporting of abortions on surveys of women in the general population. The AGI is generally recognized as compiling the most complete and accurate data on the numbers of abortions in the United States. They are published by the U.S. Department of Commerce in the Statistical Abstract of the United States. Our data are collected through surveys of clinics, hospitals and private physician offices where abortions are performed. In addition to extensive efforts to identify abortion providers, we follow up those not responding quickly to our survey with numerous contacts by mail and by telephone and supplement this information with data from state departments of health. In our survey of providers regarding abortions performed in 1985, we obtained information for 94 percent of all known or anticipated providers. Facilities for which no data could be obtained had performed 22,000 abortions in 1982. In addition, we estimate on the basis of an independent survey of private physicians, that we may have undercounted the number of abortions performed in physicians' offices by as much as 110,000, but it may have been by less. The latest estimate of the number of uncounted hospital abortions (based on an independent survey of hospitals in 1978) is 800. If these estimates are correct, the actual number of abortions in the U.S. may be about seven percent higher than our estimates.

At the same time, our national estimates are higher than the numbers reported by the federal Centers for Disease Control. In 1985, the total number of abortions reported through our survey of providers was 20 percent higher than the number reported by the CDC.

Most freestanding clinics providing abortion services do keep records. We have no indication that abortions performed in clinics are less well reported to us than those performed in hospitals or physicians' offices. In fact, since identifying clinics that offer abortion services is relatively easy compared with other types of providers, we estimate that we miss very few clinic abortions.

When women in the general population are asked to report whether they had an abortion or not, many who had abortions do not report them. This is a problem common to all surveys of women in the general population. Estimates of the extent of this underreporting come from comparisons of survey data with AGI's national provider survey results. The information presented in my testimony, such as that on who has abortions and why women choose abortion, does not come from such general population surveys, but rather from women who were actually abortion patients at the time the data were collected.

4 & 5. I am not sure on what basis you reach the conclusion that adoption is getting "short shrift" in this debate. Adoption, unlike abortion, is an issue that has universal support. There is not much controversy about whether one is for or against it, although there is substantial controversy over the conditions under which adoptions take place.

Insofar as family planning clinics are concerned, from a medical ethics point of view and according to the guidelines of the American College of Obstetricians and Gynecologists (as well as the guidelines of the Federal government under Title X), a proper emphasis on adoption is one in which family planning clinic counselors provide accurate, balanced, nondirective counseling, and referrals on request, to a woman facing an unintended pregnancy, on all options including the option of adoption. A 1982 General Accounting Office report investigating compliance with this counseling requirement at Title X-supported family planning clinics found no evidence that the mandate of nondirective counseling was being violated. This is not surprising since family planning clinic personnel are well-equipped and view it as their legal and ethical responsibility to provide pregnancy testing and offer options counseling to allow the woman to make an informed decision. Family planning clinics under Title X are also required by regulation to "provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other Federal programs." Accordingly, they provide basic infertility screening and counseling and referral for adoption services for couples who seek to adopt a child.

I hope this information is helpful to you. Please feel free to contact me if I can provide you with anything further.

Sincerely yours,

Jacqueline Darroch Forrest

Jacqueline Darroch Forrest
Vice President for Research

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AND STAFF DIRECTOR

United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 5, 1990

Dr. Vincent Rue
Co-Director
Institute for Abortion Recovery
and Research
Sir Thomas Moore Clinic
10630 Downey Avenue
Downey, CA 90241

Dear Dr. Rue:

Thank you again for testifying at the May 23, 1990 hearing. Once again, I apologize for having to leave the hearing early due to pending business on the Senate floor. You may be sure I appreciate your cooperation, time and consideration.

I have enclosed additional questions. I would appreciate it if you would answer them and return your answers to the following address by June 20, 1990:

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

If you have any questions, please do not hesitate to contact Kelly Signs at (202) 224-5701.

Again, thank you for your testimony.

Sincerely,

Howard M. Metzenbaum
United States Senate

HMM/jo

QUESTIONS FROM SENATOR METZENBAUM FOR DR. RUE

1. THE AMERICAN PSYCHOLOGICAL ASSOCIATION HAS REVIEWED THE EMPIRICAL STUDIES OF WOMEN'S REACTION TO THE EXPERIENCE OF ABORTION AND CONCLUDED THAT SEVERE NEGATIVE REACTIONS TO LEGAL ABORTION ARE INFREQUENT AND SHORT-LIVED. DO YOU DISAGREE WITH THE CONCLUSIONS OF THE APA?

2. IN YOUR TESTIMONY, YOU MAKE THE POINT THAT TEENS LACK BASIC INFORMATION CONCERNING CONTRACEPTION AND PREGNANCY AND THAT THIS CONTRIBUTES TO A HIGH RATE OF TEENAGE PREGNANCY. WE ARE ALL CONCERNED ABOUT TEENS WHO FACE UNWANTED PREGNANCIES. WOULDN'T YOU AGREE THAT WE COULD REDUCE THE NUMBER OF TEENS SEEKING ABORTIONS BY IMPROVING EDUCATION -- FOR YOUNG WOMEN AND YOUNG MEN -- CONCERNING PREGNANCY AND BIRTH CONTROL?

Institute for Abortion Recovery & Research

Vincent M. Rue, Ph.D.
Co-Director

111 Bow Street
Portsmouth, New Hampshire 03801-3819
603-431-1904

Susan M. Stanford-Rue, Ph.D.
Co-Director

22 June 1990

TRANSMITTED FACSIMILE: Jennifer O'Conner 202 224-5474

Senator Howard M. Metzenbaum
United States Senate
Chairman
Antitrust, Monopolies & Business
Rights Subcommittee
U.S. Senate
Room 224 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Metzenbaum:

Thank you for your kind letter of June 5, 1990. I was very happy to provide testimony to your committee regarding the Freedom of Choice Act of 1989.

You have requested that I respond to two additional areas that we were unable to discuss at the hearings that day.

First, I am in disagreement with the American Psychological Association on the psychological health risks of induced abortion. They, unfortunately have gone on record in any number of amicus briefs to the U.S. Supreme Court as advocating abortion. Their basic position is that abortion (1) causes no lasting significant psychological health risks; (2) provides relief; (3) can be a maturational experience for women; and (4) causes painful aftermath only for those women who were psychologically unstable before their abortion. Worse, the APA has gone on record in their amicus brief in the Hodgson case from Minnesota regarding parental notification and abortion before the U.S. Supreme Court advocating that twelve and thirteen year old girls have the same decision making abilities as adults and the same moral reasoning as adults.

These various positions are of course advocacy positions. Positions long ago over-extended beyond prudent generalizations from the literature of scientific studies available. Further, the scientific studies that the APA relies on are self-selected and extremely poor in design. For example, the APA has noted that the best "theoretical and methodological study done to date has been Dr. Brenda Major's in New York in 1985." She studied 600 women and evaluated them on psychological variables the day of their abortion and then followed them 3 weeks later. In that short time, 62% of the sample dropped out of the study! Of the one-third remaining, Dr. Major wrongly concluded that most women feel "relieved" after their abortion and display no signs of major psychopathology. We know from abundant reseach that this kind of short term study is useless because it does not take into account the long term complications of Post Abortion Syndrome.

Former Surgeon General Koop was correct in asserting that the body of literature on abortion's psychological aftermath is so flawed as to render any conclusion meaningless at this time. On March 16, 1989 Dr. Koop testified in Congress ". . . there is no doubt about the fact that there are those people who do have severe psychological problems after abortion . . . (but) if you study abortion the way many people have and see how well women feel about their decision 3 months after the actual procedure, you can be very badly misled."

The fact is the APA's position is essentially unsubstantiated and cannot be supported by the research literature. Having gone "on record" supporting abortion, it may now be difficult for these professional groups to be open to re-examining their over-extended position.

Senator Metzenbaum, if you would review the research summary I provided in my written testimony, you would see that there are psychological health risks from obtaining abortions and that they can be extremely serious. We do not know the incidence, but we know PAS exists as a clinical entity and that it may be mild, moderate or severe, affects women, men, surviving siblings and significant others, and its course may be acute, chronic, or delayed.

As to your second question, my point regarding information for teens is misinterpreted. I am not saying that the existence of information to enable an informed consent will reduce the number of unwanted pregnancies of adolescents in this country. Certainly biological information with respect to reproduction is valuable but this does nothing to <u>deter</u> teens at risk for premature sexual behavior. They are much more in need of sound educational offerings that will help them understand their sexuality within the context of their family life, value system, and future aspirations. There is also a tremendous need to provide workshops for teens and parents together to shore up family conflicts and increase parent-child communication.

My point with respect to information is that teenagers seeking abortions are <u>not</u> provided the necessary and sufficient information to make informed decisions. Further they are in most states cut off from the decision making advice and counsel from their parents because of state statutes allowing them to make the decision on their own, regardless of their maturation level. I believe teenagers should receive <u>special</u> counseling if they are contemplating abortion, including information regarding all

choices available, psychological health risks of each decision, and information describing fetal stages of development, as well as considerable consultation with their parents over a period of time. This sadly and simply is not the case in America.

Perhaps your hearings can take up these issues at a subsequent time. Thank you Senator for your important contribution to a better understanding of how abortion affects the lives of those consumers who rely on this procedure in a crisis. Please feel free to contact me if I can be of further help in the future.

Sincerely,

Vincent M. Rue, Ph.D.
Co-Director

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TERRY L. WOOTEN, MINORITY CHIEF COUNSEL
AND STAFF DIRECTOR

United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 5, 1990

Dr. Jocelyn Elders
Director of Dept. of Health
Office of the Dept. of Health
4815 West Markham St.
Little Rock, AK 72205

Dear Dr. Elders:

Thank you again for testifying at the May 23, 1990 hearing. Once again, I apologize for having to leave the hearing early due to pending business on the Senate floor. You may be sure I appreciate your cooperation, time and consideration.

I have enclosed additional questions. I would appreciate it if you would answer them and return your answers to the following address by June 20, 1990:

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

If you have any questions, please do not hesitate to contact Kelly Signs at (202) 224-5701.

Again, thank you for your testimony.

Sincerely,

Howard M. Metzenbaum
United States Senate

HMM/jo

QUESTIONS FROM SENATOR METZENBAUM FOR DR. ELDERS

1. YOU HEARD THE TESTIMONY OF MRS. EVERETT. HOW WOULD YOU, AS PUBLIC HEALTH COMMISSIONER OF YOUR STATE, REACT IF YOU FOUND OUT THAT A CLINIC SUCH AS THE ONE MRS. EVERETT OPERATED WAS OPERATING IN THE STATE OF ARKANSAS?

2. HOW WOULD YOU DETERMINE IF A PROPOSED REGULATION WAS MEDICALLY NECESSARY TO PROTECT WOMEN'S HEALTH RATHER THAN A BLATANT ATTEMPT TO DENY WOMEN SAFE MEDICAL PROCEDURES?

BILL CLINTON
GOVERNOR

Arkansas DEPARTMENT OF HEALTH
4815 WEST MARKHAM STREET • LITTLE ROCK, ARKANSAS 72205
TELEPHONE AC 501 661-2000
M. JOYCELYN ELDERS, M.D.
DIRECTOR

June 20, 1990

The Honorable Howard M. Metzenbaum
United States Senate
Committee on the Judiciary
Washington, D.C. 20510-6275

Dear Senator Metzenbaum:

As you requested, I am sending you answers to two additional questions related to the May 23, 1990 hearing.

If I can be of further assistance, please let me know.

Sincerely,

M. Joycelyn Elders

M. Joycelyn Elders, M.D., Director

MJE:wam

enclosure

28-873 O - 90 - 9

Questions from Senator Metzenbaum to Dr. Elders

1. **YOU HEARD THE TESTIMONY OF MRS. EVERETT. HOW WOULD YOU, AS PUBLIC HEALTH COMMISSIONER OF YOUR STATE, REACT IF YOU FOUND OUT THAT A CLINIC SUCH AS THE ONE MRS. EVERETT OPERATED WAS OPERATING IN THE STATE OF ARKANSAS?**

   Response

   A clinic such as the one Mrs. Everett operated does not comply with Arkansas standards for abortion facilities, so I would ask my staff to conduct an inspection. Arkansas law requires that each induced termination of pregnancy occurring in the state be reported to the Arkansas Department of Health, Division of Health Statistics, on a monthly basis. Most disturbing is the reportedly poor counseling services, particularly the way in which women were directed in making their choice. Arkansas standards require that counseling services be provided by qualified personnel:

   a. When a woman is deciding whether or not to terminate the pregnancy and needs to consider the alternative to abortion.

   b. In the preparation for the termination, and as support during and after the procedure.

   c. For discussion of contraception and plans for post partum examination.

   d. When the clinic refuses to perform the abortion for any reason.

   e. Referral to clergy, social services and appropriate mental health services shall be provided when deemed appropriate.

   A clinic being operated in the manner as described by Mrs. Everett would be immediately closed in our state and in most states in the U.S.

2. **HOW WOULD YOU DETERMINE IF A PROPOSED REGULATION WAS MEDICALLY NECESSARY TO PROTECT WOMEN'S HEALTH RATHER THAN A BLATANT ATTEMPT TO DENY WOMEN SAFE MEDICAL PROCEDURES?**

   Response

   The following question would serve as my criteria:

   Does the regulation apply to an activity which affects public health and to an activity or risk that is generally protected (and not just applied based on the delivery site of the abortion service)? If the answer to that question is yes, I believe the regulation would serve to protect the health of a pregnant woman. If no, I believe the regulation would serve to reduce access to abortion services.

JOSEPH R. BIDEN, JR., DELAWARE, CHAIRMAN

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TERRY L. WOOTEN, MINORITY CHIEF COUNSEL
AND STAFF DIRECTOR

United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 5, 1990

Ms. Jeannine Michael
174 Oxford Terrace
River Edge, NJ 07661

Dear Ms. Michael:

Thank you again for testifying at the May 23, 1990 hearing. Once again, I apologize for having to leave the hearing early due to pending business on the Senate floor. You may be sure I appreciate your cooperation, time and consideration.

I have enclosed additional questions from Senator Thurmond and myself. I would appreciate it if you would answer them and return your answers to the following address by June 20, 1990:

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

If you have any questions, please do not hesitate to contact Kelly Signs at (202) 224-5701.

Again, thank you for your testimony.

Sincerely,

Howard M. Metzenbaum
United States Senate

HMM/jo

QUESTIONS FROM SENATOR METZENBAUM FOR MS. MICHAEL

1. YOUR TESTIMONY ILLUSTRATES THAT FOR A WOMAN FACING AN UNINTENDED PREGNANCY, THERE ARE NO EASY ANSWERS AND NO EASY CHOICES. HOW DO YOU RESPOND TO THE ARGUMENT THAT IF ABORTION IS LEGAL, IT IS TOO "EASY" FOR WOMEN TO SIMPLY CHOOSE ABORTION OVER OTHER OPTIONS?

2. OPPONENTS OF ABORTION ARGUE THAT WOMEN ARE PRESSURED INTO CHOOSING ABORTION. HAS THAT BEEN YOUR EXPERIENCE IN COUNSELING WOMEN?

3. DO YOU HAVE ANY COMMENTS WITH RESPECT TO DR. RUE'S TESTIMONY THAT WOMEN SUFFER LONG-TERM AND LASTING NEGATIVE EFFECTS AFTER CHOOSING AN ABORTION?

4. COULD YOU COMMENT ON THE NEED FOR STATE-MANDATED WAITING PERIODS -- HOW DO YOU HANDLE A WOMAN WHO IS UNDECIDED ABOUT WHETHER SHE WANTS AN ABORTION?

Questions for Jeannine Michael
From Senator Orrin Hatch

1. Ms. Michael, in your entire written statement, you only devote one line to the topic of adoption as an alternative to abortion. That's in the first paragraph on page 2 when you state that "going to term and giving the child up for adoption" is one of the several alternatives that is discussed with pregnant women in your clinic's activities. Is the short shift that that your statement gives the topic of adoption indicative of the level of emphasis that adoption gets in your clinic's total counseling program?

2. In the last year, how many of your clients went full-term and either decided to raise their own babies or give them up for adoption? How many went through with abortions?

3. Do you regularly refer the women who come into your clinic for consultation to adoption agencies or other adoption experts? If not, why not?

4. Is the level of emphasis that the adoption topic receives in your clinic reflective of the emphasis that this topic receives at Planned Parenthood Clinics nationwide?

5. If there is to be any changing of the rules governing abortion, would it not be desirable to require counseling on the topic of adoption prior to the carrying out of any abortion?

June 9, 1990

1990 JUN 18

Senator Howard M. Metzenbaum, Chairman
Antitrust, Monopolies & Business Rights Subcom.
Rm 224, Dirksen Senate Ofc. Bldg
Washington, D.C. 20510

Dear Senator Metzenbaum:

It is with regret that my letter appears in so unprofessional a form. However, I received your letter and enclosed questions regarding my testimony on the Freedom of Choice Act this morning as I was leaving for London on vacation. Since I shall not return before the requested date of compliance, June 20, I am writing this while at Kennedy Airport awaiting my departure.

Please see attached sheet for my responses.

Sincerely,
Jeannine Michael, MSW, CSW
174 Oxford Terrace
River Edge, NJ 07661

Questions From Senator Metzenbaum.

Answer #1.

I take issue with the argument that the abortion option is too "easy" for women. We would never argue that the sex option is too "easy" for men.

Over the 17 years since Roe v. Wade, access has become increasingly more difficult in many states as evidenced by the number of out of state women coming to New York daily to obtain abortion services.

More important - my experience has taught me that abortion is never an "easy" choice for women. It is always thoughtful and often ambivalent. Women use many defense mechanisms to cope with the difficult but preferable choice of abortion. one must not be misled by what appears to be "easy" simply because so many women make that choice.

This kind of argument implies that women should be penalized for becoming pregnant when they either cannot or do not want to have a baby.

Answer #2 -

The testimony of Mrs Carol Everett indicates that in her abortion clinic she indeed trained "counsellors" (I use the term reluctantly) to pressure women into having abortions. This and other unethical practices which she cited verge on the criminal. In New York state her clinic would have been shut down.

The cardinal rule underlying all counseling is that the women is not advised to have an abortion, nor a baby, nor to have a baby & give it up for adoption. The counselor's posture is always neutral. Her job is to listen to the woman. Concerns & to help her weigh each option within her life situation. Even when a woman states confidently that she has considered all choices & is confident of her decision for abortion, it is the responsibility of the counselor to explore again with her the other choices.

What the opponents of abortion call counseling is not counseling, but indoctrination. I have witnessed their "sidewalk" counsellors" harassing women & pressuring them not to have abortions & have seen the women faint, become hysterical & run away from them!

Answer #3

My experience counseling women supports the findings of both the American Psychiatric Association & the American Psychological Association. There is no negative aftermath except where there have been pre-existing conditions, coercion to have an unwanted abortion by a significant other or where a deeply religious woman whose religion teaches her abortion is wrong is unable to resolve her religious conflict.

However, in most cases the negative sequelae have to do with the woman's feelings about herself & her life situation. The pregnancy becomes the crisis around which prior unresolved conflicts coalesce.

I stress, this is a very small number.

Answer #4

State mandated waiting periods serve not a useful, but instead a punitive function. If a woman is undecided, she needs to have professional counseling - not the kind Mrs Everett describes. In any reputable clinic all women are screened to determine if there is indecision about their choice for abortion. When it is present the woman is referred to an MSW social worker for in depth counseling.

When counseling a woman who is undecided, I explore what the indecision is about through focused open ended questioning until the conflict is identified. For example I ask - "How did you feel when you discovered you were pregnant?" "Have you told anyone else of your pregnancy? How did your partner/mother/father react?" "Tell me what you've thought about continuing your pregnancy." "Have you considered continuing your pregnancy and giving the baby up for adoption?" "How do you feel about abortion?"

As the answers to these questions become evident, so do the conflicts. I then deepen the questioning based upon what the conflicts are ie. "When you think about having a baby what

are the good feelings you have?" What are the things that worry you?" I do the same with the adoption and abortion options.

I then ask, based upon the pros + cons the patient has outlined, "How do you see yourself handling a baby, relinquishing your baby for adoption, or handling your feelings about abortion?" Based upon these answers I offer information on resources for each option so that she can weigh her decision within the context of her own resources + those external resources available to her.

Sometimes after such a session the patient must go away + consider what has been discussed + return for another session or as many as are needed until a decision is reached. If a woman is unable to reach a decision, she in effect has usually made a tacit decision to continue her pregnancy.

Questions from Senator Hatch

Answer #1 -

I would disagree that the adoption option is given short shrift in counselling. I refer you to my answer #4 to Senator Metzenbaum's question in which I gave a brief description of the kind of open ended questions that are asked of women in decision making counselling. All counseling proceeds from what the woman herself is struggling with + all information sharing is to inform her but not coerce her.

Answer #2 -

In 1989 The Hub registered 250 teens in their pre-natal program who went to term + kept their babies. At least another 250 adult women were referred to outside pre-natal programs + also kept their babies. Approximately 2,000 teens + adult women terminated their pregnancies. Approximately 20 women were referred to adoption agencies

Answer #3 -

When discussing the adoption option, most women respond with some variation of the following: "Even though I feel I cannot have a baby at this time, I don't think I could go through 9 months of pregnancy, give birth and then give up the baby." However, after outlining the kind of financial, housing, medical resources available, it is one of the options I suggest

exploring & often set up an appointment at an accredited adoption agency for her to discuss that option in more depth with a social worker there.

Answer #4 -

Since I believe my answers indicate that the adoption option is offered equally with the other options, I must disagree with the implication of the question that it is de-emphasized.

Since I cannot speak for Planned Parenthood nationwide beyond saying that the position of Planned Parenthood is for choice of any option, I would again reiterate that there is a misperception regarding the mission of Planned Parenthood.

Answer #5 -

Since there is already counseling on the adoption option I am unclear as to what this question suggests. However, if by counseling you mean leading the patient to consider this option instead of abortion then I reject that as an abuse of counseling & an abuse of the self-determination of the woman.

As with many parents and partners of patients who believe my job as a counselor is to convince the patient that she should make the choice they want her to make, I must explain that that is not the function of a counselor or counseling. I do not advise, suggest or insist the patient make any pre-determined choice. I listen to her ~~her~~ and her feelings about each choice & through detailed exploration of how she would cope with each choice, facilitate the decision making process that results in her discovering what is best for her at this particular time in her life with this particular pregnancy.

JOSEPH R. BIDEN, Jr., DELAWARE, CHAIRMAN
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TERRY L. WOOTEN, MINORITY CHIEF COUNSEL
AND STAFF DIRECTOR

United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 5, 1990

Dr. William F. Peterson
Chairman of Dept. of OB/GYN
Washington Hospital Center
Room 5B63
110 Irving Street, NW
Washington, D.C. 20010

Dear Dr. Peterson:

Thank you again for testifying at the May 23, 1990 hearing. Once again, I apologize for having to leave the hearing early due to pending business on the Senate floor. You may be sure I appreciate your cooperation, time and consideration.

I have enclosed additional questions. I would appreciate it if you would answer them and return your answers to the following address by June 20, 1990:

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

If you have any questions, please do not hesitate to contact Kelly Signs at (202) 224-5701.

Again, thank you for your testimony.

Sincerely,

Howard M. Metzenbaum
United States Senate

HMM/jo

QUESTIONS FROM SENATOR METZENBAUM FOR DR. PETERSON

1. COULD YOU COMMENT ON SO-CALLED INFORMED CONSENT LEGISLATION THAT WOULD REQUIRE DOCTORS TO GIVE SPECIFIC INFORMATION TO WOMEN SEEKING ABORTIONS?

2. STATISTICS SHOW THAT 90% OF ABORTIONS ARE PERFORMED PRIOR TO THE 12TH WEEK OF PREGNANCY. BASED ON YOUR EXPERIENCE, WHAT ARE SOME OF THE REASONS WHY WOMEN SEEK ABORTIONS AFTER THE FIRST TRIMESTER?

WASHINGTON
HOSPITAL
CENTER

DEPARTMENT OF OBSTETRICS
AND GYNECOLOGY

202/877-6054

June 19, 1990

Senator Howard M. Metzenbaum, Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

Dear Senator Metzenbaum:

Thank you for your recent letter. Please accept my apology for not answering prior to this date, however, I have been out of town.

In reference to the questions that you asked me, I offer the following:

1. Physicians have the moral and legal responsibility to give informed consent to all patients seeking abortion. These informed consents should cover the risks and alternatives of the abortion procedure under consideration and all of the patient's questions answered to the fullest degree possible. This responsibility, however, does and should not require that the physician give exact details as to the size of the fetus or whether it has hands and toes and fingers, etc. as some have suggested. This information is of no medical benefit to the patient and does not relate to either the difficulties or complications associated with the procedure.

2. There are multiple reasons why women seek abortions after the first trimester. I alluded to these in my pre-testimony statement and forwarded 50 copies to Ms. Kelly Signs. As I stated, they involve:

a. Irregular menses
b. Inability to find adequate funding
c. Errors made by physicians in evaluating the patients pelvic findings
d. Difficulties in finding a facility to have an early abortion such as encountered in rural areas
e. Pressure imposed by the boyfriend father of the fetus to keep the pregnancy without any tangible concrete efforts to provide support or marriage and then frequently deserting the patient
f. Denial. We have dound this plays a prominent role, especially in the younger patient. It is sort of a state-of-mind where if you don't think about it, it isn't there.
g. Continued menstruation while on the birth control pill even though the patient is pregnant
h. Learning that the pregnancy is genetically abnormal following either emniocentesis, AFP testing or sonography

110 IRVING STREET, N.W.
WASHINGTON, D.C.
20010

MEDLANTIC

i. Deterioration of medical conditions in the mother warranting termination of the pregnancy in the interest of her health and perhaps life

Hoping that this information is of value to you, and with the request that if I can be of any further help please feel free to call upon me.

Sincerely yours,

William F. Peterson, M.D.,
Chairman
Department of Obstetrics & Gynecology

WFP:dd

JOSEPH R. BIDEN, JR., DELAWARE, CHAIRMAN

EDWARD M. KENNEDY, MASSACHUSETTS
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TERRY L. WOOTEN, MINORITY CHIEF COUNSEL
AND STAFF DIRECTOR

United States Senate

COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 5, 1990

Dr. Ian Gross
Director of Perinatal Research
Yale Medical Center
333 Cedar Street
New Haven, CT 06510

Dear Dr. Gross:

Thank you again for testifying at the May 23, 1990 hearing.

I have enclosed additional questions from Senator Hatch. I would appreciate it if you would answer them and return your answers to the following address by June 20, 1990:

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

If you have any questions, please do not hesitate to contact Kelly Signs at (202) 224-5701.

Again, thank you for your testimony.

Sincerely,

Howard M. Metzenbaum
United States Senate

HMM/jo

Questions for Dr. Ian Gross
From Senator Orrin Hatch

1. Do you personally perform abortions?

2. Have you had any experiences where a child you aborted was viable? And, what occurred following your determination that the fetus was alive?

3. At our last hearing on this subject, we say a videotape of one prospective mother's ultrasound examination. There was considerable movement on the part of that fetus and one could very easily develop an emotional attachment for the life that she saw on that tape. In your opinion, would it have a chilling effect on abortion if women with unintended pregnancies were required to undergo an ultrasound examination and view the videotape of that examination prior to the time an abortion could be performed?

4. Have you witnessed instances in which a woman who had an abortion regretted having it in the aftermath and told you that she would not have had the abortion if only her parents had been consulted prior to the time the operation occurred?

5. In your opinion, shouldn't parental notification be required for minors prior to an abortion rather than being prohibited as it is under this bill?

YALE UNIVERSITY
SCHOOL OF MEDICINE

DIVISION OF PERINATAL MEDICINE
DEPARTMENT OF PEDIATRICS
Room 3-715 MU
P.O. BOX 3333
NEW HAVEN, CONNECTICUT 06510-8064
203) 785- 2320

IAN GROSS, M.D., Director
RICHARD A. EHRENKRANZ, M.D.
Clinical Director
Newborn Special Care Unit
JEFFREY B. GRUEN, M.D.
HARRIS C. JACOBS, M.D.
MARK R. MERCURIO, M.D.
SEAMUS A. ROONEY, Ph.D.
DAVID T. SCOTT, Ph.D.
JOSEPH B. WARSHAW, M.D.

1990 JUN 20 PM 2:48

June 15, 1990

Senator Howard M. Metzenbaum
Chairman
Antitruc Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

Dear Senator Metzenbaum:

Thank you for forwarding the questions from Senator Hatch. Unfortunately Senator Hatch has assumed that I am an obstetrician, who takes care of pregnant women. I am in fact a pediatrician who treats sick newborn infants. The use of the term "Perinatal" in my title often leads to this misunderstanding. My only contact with pregnant women is to counsel them prior to the birth of an infant who is likely to require intensive care.

I have answered the questions as best I can, but most are not relevant to my situation.

1. I am a pediatrician and do not perform any procedures on pregnant women.

2. See above. It is the policy of our hospital that if any baby is born alive i.e. with a heart beat, independent of the preceding circumstances, the baby is brought to the Newborn Special Care Unit.

3. Since I do not see or counsel women early in pregnancy I do not have the experience to respond to this suggestion with any level of expertise.

4. As for 3.

5. This is a complex issue. I would think that minors who have a good relationship with their parents might consult them before making a major decision. Where the relationship has broken down, parental involvement could in some situations be counter productive and not in the best interests of the minor child. For example, I can visualize a situation where a minor might be ambivalent about proceding with an abortion and where the parents would encourage it, to avoid the personal embarassment of having a grandchild out of wedlock.

Sincerely

Ian Gross

Ian Gross, M.D.
Professor of Pediatrics
Director of Perinatal Medicine

JOSEPH R. BIDEN, JR., DELAWARE, CHAIRMAN
EDWARD M. KENNEDY, MASSACHUSETTS
HOWARD M. METZENBAUM, OHIO
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AND STAFF DIRECTOR

United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 5, 1990

Dr. John Nelson
President
Utah Medical Association
540 East 500 South
Salt Lake City, UT 84102

Dear Dr. Nelson:

Thank you again for testifying at the May 23, 1990 hearing.

I have enclosed additional questions from Senator Hatch. I would appreciate it if you would answer them and return your answers to the following address by June 20, 1990:

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and Business Rights Subcom.
Room 224 Dirksen Senate Ofc. Bldg.
Washington, D.C. 20510

If you have any questions, please do not hesitate to contact Kelly Signs at (202) 224-5701.

Again, thank you for your testimony.

Sincerely,

Howard M. Metzenbaum
United States Senate

HMM/jo

Questions for Dr. John Nelson
From Senator Orrin Hatch

1. At our last hearing on this subject, we saw a videotape of one prospective mother's ultrasound examination. There was considerable movement on the part of that fetus and one could very easily develop an emotional attachment for the life that she saw on that tape. In your opinion, would it have a chilling effect on abortion if women with unintended pregnancies were required to undergo an ultrasound examination prior to the time an abortion could be performed?

2. More and more babies are surviving. While the viability has moved from 28 to 24 or 22 weeks, will medical science allow us to save more and more babies? What is the survival rate of babies born at 28 weeks? Was this the case in 1973?

3. Should a candidate for abortion also be required to undergo adoption counseling prior to having an abortion?

   Are all options discussed now?

4. Dr. Nelson, in previous hearings before this committee, we have heard of an exodus of OB/GYNs because of the high cost of medical malpractice insurance premiums. Would the fact that the bill does not require a patient's informed consent lead to a substantial increase in malpractice insurance

premiums and thus drive more OB/GYNs out of practice for economic reasons?

5. You have stated that under the terms of S. 1912, you would not be protected legally from having to do procedures that you find to be morally offensive, and that you would have to stop practicing medicine altogether if you were compelled to perform such procedures as abortions. Do you think such resignations would be widespread in Utah and in other areas where a large number of physicians could be expected to have objections to this bill on religious grounds?

6. Dr. Nelson, have you had patients who have had abortions?

Have you performed abortions?

It's my understanding that there are a number of health problems for women who have abortions. There are studies which show there are physical reactions associated with abortion: hemorrhaging, subsequent fetal malformations, cervical trauma, ectopic pregnancy, breast cancer, pelvic inflammatory disease, infertility, RH isoimmunization, subsequent miscarriage, and death. In addition, there are a number of studies which show that a significant number of women who have abortions experienced one or more negative psychiatric sequelae. These include symptoms of guilt, anxiety, depression, and psychoses.

Do you agree that these are potential medical outcomes?

Did you find these in your practice?

7. Have you witnessed instances in which a woman who had an abortion regretted having it in the aftermath, and told you that she would not have had the abortion if only her parents had been consulted prior to the time the operation occurred?

8. In your opinion, shouldn't parental notification be required for minors prior to an abortion rather than being prohibited as it is under this bill?

UMA
750 EAST FIFTH SOUTH STREET
SALT LAKE CITY, UTAH 84102-2707
(801) 355-7477

June 19, 1990

Senator Howard M. Metzenbaum
Chairman
Antitrust, Monopolies and
Business Rights Subcommittee
Room 224, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Metzenbaum:

Enclosed are my responses to the questions from Senator Hatch. I appreciate your allowing me to respond to them. If I may be of any further assistance, please do not hesitate to call me.

Sincerely,

John C. Nelson, M.D. /ls

JOHN C. NELSON, M.D.
President

JCN/vp

Enclosure

ANSWERS FOR SENATOR ORRIN HATCH
FROM JOHN C. NELSON, M.D.

1. At our last hearing on this subject, we saw a videotape of one prospective mother's ultrasound examination. There was considerable movement on the part of that fetus and one could very easily develop an emotional attachment for the life that she saw on that tape. In your opinion, would it have a chilling effect on abortion if women with unintended pregnancies were required to undergo an ultrasound examination prior to the time an abortion could be performed?

ANSWER: My opinion is that if a person who was pregnant saw an ultrasound evaluation of her infant, she would have an emotional response which is the beginning of the bonding experience. Bonding is the psychologic adjustment to a newborn baby, which is very strong and very real. Even when the infant has had significant abnormalities in terms of its development, I am impressed that the mother most times will bond with the infant. Therefore, yes, I believe that this may have a chilling effect on abortion.

2. More and more babies are surviving. While the viability has moved from 28 to 24 or 22 weeks, will medical science allow us to save more and more babies? What is the survival rate of babies born at 28 weeks?

ANSWER: The question of what medical science will do is limited by one's imagination, the ability we have to do research, and the cost associated with this. There are many societal decisions which need to be made. While we do not know the lower limit of viability at the present time, that limit has been steadily pushed back since my time in residency which ended in 1975. At that time a 32-week infant was lucky to survive. Now, as you have pointed out, we are down to 23 or 24 weeks of gestational age where the infant may survive. There are some serious ethical questions to be debated here as well as those of the bottom line. I would point out, however, that we as a profession feel that we need to continue to work on this area and that we will continue our research into ways to help these very young infants be viable. At the University of Utah Medical Center or at LDS Hospital in Salt Lake City an infant born at 28 weeks with no other abnormalities or diseases has between a 95 - 97 percent chance of surviving safely. This would include such things as the use of fetal ultrasound to document the age and the use of Surfactant, which is used to help the infant's lungs become mature more rapidly. We also use steroids in the pregnant mother to help her make the infant mature more rapidly.

Was this the case in 1973?

ANSWER: Senator, this was definitely not the case in 1973. At that time viability was between 32 and 34 weeks and was very,

very limited because of the inability we had to care for the infants. With neonatal intensive care units, with continuous positive airway pressure, with improved intubation techniques and especially with the use of Surfactant, we are saving much younger babies than ever before.

3. Should a candidate for abortion also be required to undergo adoption counseling prior to having an abortion?

ANSWER: My feeling is that when a person is pregnant she ought to be given all three options, not just one or two. The options are: (1) to have the baby and keep it, (2) to have the infant and adopt it out, or (3) to terminate the pregnancy. In terms of being fair with the patient and informing her of the risks and benefits of her decision, it would seem to me that the appropriate thing to do would be to give her the risks and benefits of each of those options. While at first blush it may appear that one or the other of the options is the easiest, when one looks at it more carefully, that may not be the case for the given patient. For example, there is no way for the prospective mother to know how she might feel a year or five down the road if in fact she terminates her pregnancy. Therefore, I think it's important for her to understand the ramifications of any decision in this medical procedure just as it would be in any other medical procedure.

Are all options discussed now?

As to whether all options are discussed now, that varies from institution to institution. It is my distinct impression that at some institutions when counseling is talked about for the prospective mother to be aborted, the only question that is asked is, "When do you want to have the abortion?" I believe that it is important for the prospective mother who is often young, often unmarried and often in a state of distress to be able to hear the ramifications of the options and to have some time to think about it.

4. Dr. Nelson, in previous hearings before this committee, we have heard of an exodus of OB/GYNs because of the high cost of medical malpractice insurance premiums. Would the fact that the bill does not require a patient's informed consent lead to a substantial increase in malpractice insurance premiums and thus drive more OB/GYNs out of practice for economic reasons?

ANSWER: Certainly there is the possibility that without informed consent there would be an increase in professional liability or malpractice suits. Currently informed consent is a principal point in the defense of a physician who has an action brought against him or her. Therefore, if the proposed bill were to eliminate this defense, the physicians would have no legal leg on

which to stand. My impression is that this would have a chilling effect on those individuals who may seek obstetrics and gynecology as a career. It may significantly limit the patients that individuals would be willing to see and I believe that access, particularly in already underserved areas such as the urban inner cities and the rural areas of states such as Utah, would be adversely affected.

5. You have stated that under the terms of S. 1912, you would not be protected legally from having to do procedures that you find to be morally offensive, and that you would have to stop practicing medicine altogether if you were compelled to perform such procedures as abortions. Do you think such resignations would be widespread in Utah and in other areas where a large number of physicians could be expected to have objections to this bill on religious grounds?

ANSWER: I wouldn't be able to comment on that because it would be a very personal decision. In my part of the country where there is a significant culture who believes that abortions are morally wrong, I believe that there are many physicians who may choose to leave the practice of obstetrics and gynecology because of this provision. However, I am more concerned that it may spread beyond obstetrics and gynecologists. Theoretically, my license suggests that I can practice medicine and surgery "in all its branches." This license is the same for all other specialties. Specifically, it would be the same for family physicians, general surgeons, and other types of surgical specialties. Theoretically, it would be possible that if obstetricians and gynecologists were not available to perform abortions, other specialists, such as surgeons, would have to do the procedure. I am also concerned about the chilling effect it may have on nursing personnel and other hospital personnel who find this act to be morally offensive. Therefore, I am not only concerned about the potential of physicians resigning from the practice of obstetrics and gynecology but also potentially the loss of other health care providers, especially registered nurses, who are already in short supply.

6. Dr. Nelson, have you had patients who have had abortions?

ANSWER: Yes, I have had patients who have had abortions.

Have you performed abortions?

ANSWER: No, I do not perform abortions.

It's my understanding that there are a number of health problems for women who have abortions. There are studies which show there are physical reactions associated with abortion: hemorrhaging, subsequent fetal malformations, cervical trauma, ectopic pregnancy, breast cancer, pelvic

inflammatory disease, infertility, RH isoimmunization, subsequent miscarriage, and death. In addition, there are a number of studies which show that a significant number of women who have abortions experienced one or more negative psychiatric sequelae. These include symptoms of guilt, anxiety, depression, and psychoses. Do you agree that these are potential medical outcomes?

ANSWER: There can be significant health problems for people who have abortions. The list of traumas and untoward effects which you have mentioned appears to be accurate.

Perhaps the concern I have the most is the possibility of subsequent infertility. When a person does a suction curettage, it is very important that it is done gently and that only the lining tissue, called endometrial tissue or decidual tissue, is removed. If more tissue is removed, there is the distinct possibility (if not the probability) that the anterior or front wall of the uterus may be fused to the posterior or back wall of the uterus. There may be a web of synechiae or scars which may obliterate the endometrial or uterine cavity. This is a real concern and particularly would be increased because of the lack of provision within the bill (S. 1912) to mandate that only physicians or trained personnel would perform the procedure. This may lead to a physical cause of infertility which is very difficult to treat successfully.

Infection is always a concern when one puts an instrument inside the uterine cavity, which is normally a sterile area. Hemorrhage is also a significant complication, not only in the short term but in the long term as well. Inasmuch as facilities are not regulated by this bill, I have a concern that if there were a significant hemorrhage, there would not be a facility available either to ligate the hypogastric artery, which is the main blood supply to the uterus, or to perform an emergency hysterectomy.

I am also concerned about the ability to look at the laboratory report. It is essential to look at the lab report to make sure that the appropriate tissue is removed. There are circumstances where a hydatid mole may have formed which if left untreated may become malignant. This process is called choriocarcinoma. This may be life threatening to the mother. I am also concerned about what is known as the Arias-Stella phenomenon. This occurs when the patient is pregnant but perhaps in the fallopian tube. The decidual reaction continues in the uterus, making the uterus enlarged so that when the suction curettage is performed the operator suspects that the tissue has been removed. In reality the physician must see the word villi on the path report to be sure that the tissue has been removed. If an ectopic or tubal pregnancy has been undiagnosed, the patient may have severe

trauma and if this is undiagnosed, this will certainly and surely lead to the patient's death by exsanguination.

Did you find these in your practice?

I have found some of these conditions in patients in my practice, particularly infertility, Rh isoimmunization and subsequent miscarriage. I have also seen cervical trauma and significant hemorrhage.

7. Have you witnessed instances in which a woman who had an abortion regretted having it in the aftermath, and told you that she would not have had the abortion if only her parents had been consulted prior to the time the operation occurred?

Perhaps the most difficult symptoms with which to deal are the psychiatric ones because of the tremendous feeling of guilt and remorse many times stated by the patient as having been given "no choice."

Therefore, I am lead to believe that my previous answer was correct in that many times the patients are not counseled about other options. I have witnessed occurrences where people are very sorry and have a great deal of remorse over having had a previous abortion. The sense of isolation experienced by the pregnant female who is often very young and/or out of wedlock places her in a very vulnerable position. Often times even the prospective father of the baby abandons the patient. Therefore, she has no place that she can go for help. Inasmuch as parents are looked upon as a potential ally and the prospective mother does not wish to damage that relationship, she often chooses not to go to her parents. I believe that a parent, even a parent who is visibly upset, is a better advocate for his or her child than the best of counselors. The reason for this is that the parent has a bond attached to that child and would certainly want nothing done to harm the child. I also believe that the parent would be very upset if any type of surgical procedure such as an appendectomy or the fixing of a fracture or other injury were to occur without parental notification. I find it strange to single out this particular surgical procedure from all the others as one that does not need parental consent, particularly given the potential dangers.

8. In your opinion, shouldn't parental notification be required for minors prior to an abortion rather than being prohibited as it is under this bill?

I believe that a parental notification requirement is an absolute must to make this an appropriate bill. It is inappropriate in my view to have this procedure singled out as different from all other surgical procedures which also would need parental consent. I believe that the more information and the more caring that can be given to a patient who is in this type of stress the more helpful it would be in the long run to the patient.

Ms. SIGNS. The witnesses are excused. We will be submitting questions in writing, and you can enter your responses for the record.

Thank you. The hearing is adjourned.

[Whereupon, at 12:04 p.m., the committee was adjourned.]

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